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Hank Hudson, Division Administrator

REPORT TO THE GOVERNOR AND LEGISLATIVE JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Regarding the:

Partnership to Strengthen Families Project

Prepared by:

Mary A. Trankel, Ph.D., Evaluation Contractor
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December 31, 1995

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CHILD & FAMILY SERVICES DIVISION of the

MONTANA
Department of Public Health & Human Services

Hank Hudson, Division Administrator

FOLLOW-UP SUMMARY
FOR
REPORT TO THE GOVERNOR AND
LEGISLATIVE JOINT APPROPRIATIONS
SUBCOMMITTEE ON HEALTH
& HUMAN SERVICES

Partnership to Strengthen Families Project

Report Dated: December 31, 1995

This summary is a follow-up to the report recently disbursed regarding program and evaluation activities conducted under the ***Partnership to Strengthen Families Project***, Program Year 1995. During the 1995 Legislative Session, the Partnership Project Coordinator organized several presentations to the Legislative Joint Appropriations Subcommittee on Health and Human Services. During those presentations, *Trankel Research & Analysis* explained the procedures and assessment tools that had been developed and were being utilized by Partnership Project staff in order to provide reliable and valid outcome data on program effectiveness.

It was explained during the 1995 Legislative Subcommittee presentations that outcome data would not be available for at least two years. However, the committee requested that details and progress toward

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It was explained during the 1995 Legislative Subcommittee presentations that outcome data would not be available for at least two years. However, the committee requested that details and progress toward implementing the outcome evaluation be presented in an **Interim Project Report at the end of 1995**. These details are presented in Sections II and III of the above referenced report. The table on the following page summarizes information about the Partnership Project sites from Appendix A of that interim report.

As anticipated, a great deal of startup time was invested in training Partnership staff on procedures necessary to ensure reliability and validity of the data gathered. In addition, a fairly complex database management system was developed in order to provide a user friendly means of data entry and report generation that could be installed at each program site. As explained to the Legislative Subcommittee, post-tests will not be administered to client families until they have received at least one year of intensive home visitation services, because the literature strongly suggests this is the minimum amount of time necessary to produce positive changes among at-risk families.

In addition to the quantitative data analysis now in place at Partnership Project sites, Trankel Research & Analysis and the Partnership Project Coordinator are in the process of conducting a qualitative evaluation of the overall program. The purpose of this evaluation strategy is to summarize and analyze the program process as it has evolved in Montana, with an emphasis on exploring differences that have emerged at rural vs. urban program sites. This qualitative analysis will focus on successes and barriers experienced by Partnership staff; innovative strategies that have been developed to overcome both system and family barriers to program success; the relative success of different collaborative efforts throughout the state; and *best practices* which appear to be most effective in producing positive client change. This portion of the evaluation is explained in Section IV of the 1995 Interim Legislative Report.

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PARTNERSHIP TO STRENGTHEN FAMILIES PROJECT							
Reg	**Site**	**Contractor**	**Service Start**	**Budget 94-95**	**Budget 95-96**	**Families Referred**	**Families Enrolled**
1	Sidney	Hi-Line Homes Programs, Inc.	1/1/95	$25,000	$33,500	19	11
1	Glasgow	Hi-Line Homes Programs, Inc.	1/1/95	$25,000	$30,050	13	10
1	Glendive	Dawson County Health Department	1/1/95	$25,000	$33,000	11	7
1	Miles City	Developmental Educational Assistance Program	1/1/95	$25,000	$33,750	18	8
2	Havre, Chinook, Rocky Boy, Ft. Belknap Reservations	Human Resource Development Council	11/1/94	$172,170	$172,170	90	82
3	Billings	Family Support Network	12/1/94	$115,317	$133,400	70	43
3	Billings	Family Tree	2/1/95	$6,570	$56,711	24	24
3	Billings	Young Families Program	12/20/94	$13,140	$6,570	25	25
4	Anaconda	Anaconda Family Enrichment Council	11/1/94	$50,000	$50,000	43	21
4	Dillon	Women's Resource Center	2/1/95	$50,000	$74,136	30	25
4	Granite County	Granite County	2/1/95	$24,700	$24,700	6	4
4	Deer Lodge	Child Start, Inc	2/1/95	$25,300	$26,300	10	10
4	Bozeman	Gallatin City-County Health Department	1/1/95	$55,000	$100,000	29	14
2	Great Falls	Opportunities, Inc	7/1/95		$35,000	12	12
5	Eureka	Nurturing Center (Kalispell)	1/1/95	$30,831	$41,107	15	12
5	Missoula	Missoula County	1/1/95	$72,036	$134,000	90	63
5	Libby/Troy	Lincoln County Champion Group Home	12/1/94	$146,458	$198,854	49	45
					Total for 1994-1995	**554**	**416**

Condensed site information prepared by Trankel Research and Analysis

March 6,1996

LIST OF ACRONYMS

BN	*Basic Needs/Stress Factors Checklist* (developed for the Partnership Project)
CFS	Child & Family Services Division of DPHHS
DPHHS	Department of Public Health & Human Services
FS/FP	Family Support & Family Preservation Act (federal legislation)
FLS	*Family Life Survey* (instrument developed for the Partnership Project)
LES	*Life Experiences Survey* (instrument developed for the Partnership Project)
PP	Partnership Project
TRA	*Trankel Research & Analysis*, Evaluation Contractor for the Partnership Project

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APPENDIX C: **Interview Instruments Used to Gather Qualitative Data Regarding *Best Practices* and *Community Collaboration Efforts*; Survey to Determine Training Needs of Project Supervisors.**

APPENDIX D: **TECHNICAL ASSISTANCE BRIEFS:**

1. *Common Questions & Answers Regarding Evaluation Procedures* (blue)
2. *Program Evaluation Components* (yellow Tech Brief)
3. *Definitions of Research Terms* (purple Tech Brief)

REPORT TO THE GOVERNOR AND LEGISLATIVE JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Regarding:

Partnership to Strengthen Families Project

SECTION I: INTRODUCTION

The 1993 Montana State Legislature passed three bills recommended by the Joint Interim Subcommittee on Children and Families. These were: **House Bill 18**, which established the *Montana Family Policy Act*; **Senate Bill 34**, which created an *Interagency Coordinating Council on Prevention*; and **House Bill 19**, which established a Legislative Joint Oversight Committee on Children and Families. Through this legislation, the now Child and Family Services Division (CFS) of the Department of Public Health and Human Services (DPHHS) had authority, for the first time, to develop programs focused on *prevention* -- as opposed to providing only *intervention* services for families.[1]

In keeping with its new mission to *protect children and adults by supporting family and community strengths*, CFS developed the ***Partnership to Strengthen Families Project***. The Partnership Project (PP) was designed to strengthen families, decrease the incidence of child abuse and neglect in two target populations, and reduce the need for out-of-home care by supporting a comprehensive, coordinated, and proactive array of community-based services for families at risk for child abuse and neglect. After an intensive review of information on successful prevention programs across the United States, CFS identified two categories of overburdened families to be targeted for this project:

1. Families at risk of abuse and neglect who <u>have not been referred to CFS</u>, and whose children are prenatal to three years old; and

2. Families who <u>have recently been referred to CFS</u>, but whose children are not at imminent risk for removal.

CFS anticipates having the greatest positive impact by focusing its limited prevention resources on families with the potential for long-term success. According to the literature, it may be possible to interrupt the learned cycle of abuse and neglect if prevention services are targeted to young adults who are just beginning to develop their parenting skills. Such programs have been most successful when they reach out to new parents before the child is born, and/or immediately after the birth of their child. This was the reason for choosing the first target population for the Partnership Project. The second group was selected in order to explore the

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[1] See page "i" for definitions of acronyms used throughout this report.

potential impact of prevention efforts targeted toward reducing the need for foster care and other expensive intervention services. By reaching out to families who may be in crisis or have displayed a tendency toward use of aggressive parenting techniques, it may be possible to teach caregivers new coping skills and child behavior management strategies that will prevent the need for future CFS intervention.

The Partnership Project is supported by funds captured through reimbursement from the federal government for child protective services rendered by the state. This strategy is called *refinancing*. One million dollars made available to the State of Montana through refinancing efforts was invested in 17 Partnership Project community sites during Fiscal Year 1995. These funds were divided among the state's five CFS regions by taking into consideration the following factors: 1) *population*; 2) *community risk factors* related to child abuse and neglect; and 3) *history of successful collaboration efforts* among community agencies serving children and families.

During Fiscal Year 1996, $1,228,261 was available to fund 18 Partnership Project sites through the same refinancing efforts. In addition, $320,101 was available to the state from Montana's allocation under the federal Family Support and Family Preservation Act (FS/FP). This money was used to fund an additional 6 communities who were interested in providing services similar to those programs operating under the Partnership Project. Thus, there are currently a total of 24 community prevention programs in place under the combined Partnership Project and FS/FP funding sources.

Appendix A includes a one-page descriptive summary of the Partnership Project sites and the services they currently provide. Some sites are not included in this appendix because they are still in the initial planning or startup stage, and thus have not made final decisions regarding the types and methods of services they will deliver. Project sites not described in Appendix A include: Helena/Greater Lewis and Clark County; Butte/Silver Bow City/County; Kalispell/Flathead County; Lewistown/Fergus County; Columbus/Stillwater County; Hamilton/Ravalli County; and Thompson Falls/Sanders County.

Appendix B includes some initial demographic and risk factors information about families being served in Yellowstone County, which is one of the largest Partnership Project sites.

Appendix C contains copies of the interview instruments used for a Process Evaluation of *best practice* methods and the relative success of community collaboration efforts across the state.

Appendix D includes copies of Technical Assistance Briefs prepared by *Trankel Research & Analysis* to help explain program evaluation procedures.

SECTION II: OUTCOME EVALUATION

When human service professionals design a program to alleviate a social problem, they generally seek funding from a government or nonprofit agency willing to invest in their treatment ideology. Those funding agencies typically request a yearly report designed to demonstrate the success of the program. Until recently, government agencies and nonprofit funding sources have been satisfied with program summaries that document the numbers and types of activities conducted, and the number of clients who participated in activities or received services. Within the past few years, however, government officials and nonprofit organizations have become more sophisticated and knowledgeable about research and statistical data analysis. As a result, they have begun to expect more than a simple recounting of program activities. They want to know what *effects* a program has had on the attitudes and behaviors of program participants. In other words, they want hard statistical data (outcome measures) designed to demonstrate program effectiveness.

Most human service programs are designed to *change* some type of social behavior. In order to be able to change human attitudes or behaviors, we must first be able to predict *when* (under what circumstances) those behaviors are likely to occur; that is, what are the factors that *cause* this particular *effect*. Available research provided strong evidence that prevention funds should be directed to families early enough in the family developmental life cycle so that interventions could make a difference in family functioning. In this way, it should be possible to reduce the risk factors associated with abuse and neglect before negative parenting practices are established. In addition, Partnership home visitors try to build on existing family strengths in order to enhance the resiliency factors associated with positive parenting outcomes.

Since it is not possible to measure something that does not happen, we can't be sure how many times a program has prevented parents from abusing or neglecting their children. However, if the logical approach to prevention is to try to reduce the risk factors associated with abuse and neglect (the presumed *cause*, or negative effect), then the logical approach to evaluation is to measure potential change in the associated risk and resiliency factors (the expected outcomes, or *positive effect*).

A thorough program assessment should consist of at least four components: 1) a demographic and risk profile of clients; 2) worker assessments or ratings of client needs and strengths; 3) service satisfaction surveys; and 4) client self-report assessment tools or other client-based outcome measures. By including several different types of data, we gain a more complete picture of the complex factors involved in human behavior. This may help inform us not only about what changes occurred or did not occur, but also why.

Most program providers are adept at gathering data sufficient for the first three components described above. Developing assessment tools and analyzing data for the fourth research component requires the assistance of a trained researcher or someone who can perform statistical data analysis. It is not appropriate to make claims or assumptions about change by a simple visual comparison of pre-test and post-test scores on an assessment tool. The

appropriate statistical tests must be conducted to determine whether there has been a change in attitude or behavior that is greater than that which could have been expected through chance alone.

However wisely designed, a program evaluation will only be as successful as the people who gather and enter the data. Both staff and clients must be educated about the importance and use of the data. If possible, all affected parties should be encouraged to participate in developing and refining the research design. In addition, the data gathered for program evaluation should serve some useful function for the program staff. We are attempting to accomplish this task in Montana through development of a relational database program that allows TRA to create user friendly data entry forms and reports. The purpose of this database is to make the assessment data readily available to staff for their own planning purposes.

Our approach to developing an evaluation plan that makes sense to program staff and administrators is to help them visualize how their program activities are related to their program goals and to the tools developed for their program assessment. **Figure 1**, page 10, shows portions of an evaluation plan developed for one of the Partnership Project sites in Montana. The reader is directed downward through the vision and mission statements, then left to right across the cells in each table row. The statements proceed from the most abstract level of thinking about program goals (*objectives*), to the more concrete and specific *activities* and *expected outcomes* related to those goals. The final column specifies the data collection instruments (*assessment tools*) designed to measure each specific outcome. In this way, program staff can see how their original abstract ideas have been ***operationally defined***,[2] and how the assessment tools developed for the evaluation relate directly back to their original project mission and goals.

Before funds were disbursed to any project site, CFS asked that participating agencies prepare a proposal describing their site-specific goals and expected outcomes. Included within each project proposal was a budget describing how funds would be disbursed among participating agencies, and the types of salaries or services that would be provided. *Trankel Research & Analysis* (TRA), the Evaluation Contractor, used these individual project proposals to develop evaluation plans for each participating site. It soon became apparent that the goals described by each site were strikingly similar, and could therefore be summarized for all projects as follows:

1. Promote positive parenting skills and attitudes toward healthy family functioning.

2. Educate caregivers regarding healthy child development, appropriate expectations for their child(ren)'s behaviors and appropriate methods of discipline.

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[2] See the purple Technical Assistance Brief in **Appendix D** for definitions of research terms that appear in ***bold italics*** within this report.

3. Make appropriate referrals to community resources and encourage families to effectively utilize these resources in order to promote family self-sufficiency.

4. Provide appropriate support services (such as child care and transportation) to remove barriers to participation in services and family development activities.

5. Support families in becoming empowered to be their own most effective problem solvers and change agents.

6. Help families develop social support systems to alleviate social isolation and promote family self-sufficiency.

7. Promote partnerships (collaboration) among existing community organizations to provide a comprehensive continuum of services for families at-risk.

8. Enhance and expand existing services to provide a nurturing community environment for healthy family and child development.

Note that the first six goals are focused on "best practices" designed to improve *family functioning*, while the last two goals are focused on improving *community collaboration*. The overall goal of each project is similar to the CFS Division goal -- to create and maintain healthy living environments for children and adults by building upon family and community strengths.

A good deal of preparation time must be spent at the beginning of every evaluation process to help staff work through their questions and concerns before an attempt is made to implement data collection activities. This is because the initial reaction of staff to the idea of a program evaluation based upon client self-assessment (survey) tools is likely to be resistance, based partly upon fear of the unknown. This is not surprising, since standardized research practices do not make sense to people at first. Staff must have time to ask questions and express their natural concerns about evaluation before they can feel comfortable trying to implement procedures that at first seem unnecessary or intrusive. In the past, many staff have conducted their own worker-generated assessments of client outcomes. It is very difficult to establish the reliability and validity of such assessment tools, because the workers are in control of the analysis, and thus of the outcomes. This constitutes a built-in ***threat to validity***. Since staff have no control over how clients will respond to a survey developed by an outside evaluator, it is understandable that they may worry about how such *findings* will be interpreted, and whether their jobs will be in jeopardy as a result.

Partnership staff expressed several concerns when the evaluation process was first implemented last year, but their experience has shown that most fears were ungrounded. This is because often our common sense predictions about human behavior are wrong (about as often as they are accurate). Many Partnership Project staff predicted that families would not cooperate in filling out the assessment forms. These predictions were not borne out. Instead, as the research literature suggested, those families with the highest risk factors have generally

been the most willing to fill out the surveys. In addition, some staff were afraid that use of these tools would inhibit discussions and cause prospective families to refuse services. In reality, several family workers have reported that these tools are very helpful as a means of starting productive problem-solving dialogues with new families. Those who have delayed administration of the tools until they had a chance to establish rapport with a family have noted with regret that the family members answered questions on their pre-test in a different way than they would have if the survey had been administered as a true ***baseline measure*** (i.e., prior to receiving any Partnership services). Therefore, it appears that these tools may well be useful as a measure of positive change that can result in a fairly short period of time.

Unless a concerted attempt is made to gather this type of client self-report data, we will not have ***valid*** and ***reliable*** outcome measures for use in determining program effectiveness. We have asked that Partnership Project staff and other providers participating in the statewide evaluation give the recommended process a fair chance. That is, we ask that they try not to introduce subjective bias by making predictions ahead of time that people will react in a negative fashion. Such expectations are unconsciously communicated to survey respondents, who then act in accordance with our expectations for their behavior. TRA has found that initial training in research procedures and explanations for development of the assessment tools is not sufficient. Staff and administrators need ongoing technical assistance and training in research procedures and data entry in order to ensure that they are comfortable with the evaluation process, and that the resulting data is gathered in reliable and valid manner.

The Division of Child & Family Services of the Department of Public Health & Human Services has never before engaged in such a thorough, systematic, statewide evaluation of social service programs. Thus, TRA has spent a great deal of time providing the extensive on-site technical assistance that is necessary to support an endeavor of this magnitude. The tables below depict the travel and technical support activities performed by TRA for the Partnership Project during the past year.

ACTIVITY	TOTAL
Evaluator hours specific to Partnership Project	1329.75
Employee hours specific to Partnership Project	1025.00
Evaluator hours specific to Crisis Nursery Project	57
Employee hours specific to Crisis Nursery Project	23.15
Site visits	42
Computer database training (at the site)	35
Data Collection forms developed, revised and/or adapted	23
Sites with Paradox database program installed	13
Sites – data entry completed/assisted by TRA staff	8

TRAINING AIDS DEVELOPED AND DISTRIBUTED
Instruction Manual for PSF Paradox users
Technical Briefs: Definitions of Research Terms Program Evaluation Components Common Questions and Answers Developing a Sound Program Evaluation General Guidelines for Developing a Survey

TRANKEL RESEARCH AND ANALYSIS - 1995 Travel Partnership Project and Crisis Nursery Grant

DATE	CITY	DESCRIPTION
1/5-1/6 '95	Havre	Site visit, Paradox training/data entry
1/13/95	Missoula	Site visit, Evaluation training
1/19/95	Anaconda	Site visit, Paradox training
1/20/95	Bozeman	Site evaluation, Paradox training
1/25/95	Libby	Site visit, Paradox training
1/27/95	Eureka	Site visit, Paradox training/data entry
1/28/95	Helena	Cultural training
2/6-2/9 '95	Libby	Site visit, baseline data gathering
2/16/95	Deer Lodge	Paradox training
2/16/95	Anaconda	Paradox training
2/20/95	Havre	Site visit
2/28/95	Great Falls	Evaluation training
3/10/95	Dillon	Paradox training
3/11/95	Helena	Paradox training
3/12-3/18 '95	Billings	Site visit, Baseline data gathering, Paradox training
3/22/95	Helena	Paradox training, Evaluation presentation
3/24/95	Havre	Paradox training, creating files
3/30/95	Anaconda	Paradox training
4/3/95	Missoula	Paradox training
4/5/95	Hamilton	Paradox training

DATE	CITY	DESCRIPTION
4/17/95	Billings	Site visit, Paradox training
4/18/95	Miles City	Site visit, Paradox training
4/19/95	Glendive	Site visit
4/20/95	Glasgow	Site visit, Paradox training
4/27/95	Dillon	Site visit, Paradox training
5/30/95	Billings	Site visit, Paradox training
6/7/95	Havre	Site visit, Paradox training
6/13/95	Hamilton	Paradox training
6/15/95	Anaconda	Paradox training
6/20/95	Missoula	Paradox training
6/22/95	Helena	Paradox training
7/8/95	Missoula	Paradox training
7/10/95	Rocky Boy	Site visit, data gathering
7/10/95	Chinook	Site visit, data gathering
7/18/95	Helena	Paradox training
7/27/95	Dillon	Paradox training and data update
7/30/95	Miles City	Paradox training, data gathering
8/2/95	Glasgow	Site visit, Paradox training
8/4/95	Miles City	Site visit, Paradox training
8/5/95	Billings	Site visit, Paradox training, repairing files
8/21/95	Hamilton	Paradox training
8/24,8/25 '95	Glendive	Site visit, Paradox training
8/27/95	Libby	Site visit, Paradox training
8/28/95	Eureka/Kalispell	Site visit, data gathering
9/1/95	Browning	Site visit, Evaluation training
9/8/95	Bozeman	Site visit, data gathering
9/10/95	Billings	Site visit, Paradox training, computer setup
9/14/95	Columbus	Site visit, Evaluation training
9/14/95	Great Falls	Site visit, Evaluation training
9/21/95	Helena	Site visit, Paradox training

DATE	CITY	DESCRIPTION
9/23/95	Missoula	Site visit, Paradox training
11/27/95	Missoula	Paradox training
12/12/95	Billings	Site visit, Paradox training, Data gathering
12/16/95	Helena	Paradox training

It is wise to remember that intervention programs and evaluation strategies should be assessed not in terms of whether problems occur or desired outcomes are achieved. Rather, success should be measured in terms of how well staff are able to identify problems and devise appropriate solutions to overcome barriers to success. We can learn as much from what does not work as we can from what does work. In fact, we often learn more from our failures because we are not as likely to examine reasons for success. Instead, we may be tempted to simply replicate a successful program in a different area without examining whether those factors which caused program success can be reproduced within a different context.

Rather than approach evaluation as a means of comparing specific programs or program providers, a more productive approach is to analyze the factors that contribute to success or failure. That is, try to answer such questions as: 1) what types of clients respond in what ways to different types of services or treatment interventions; and 2) how long does it take to produce certain outcomes for different types of clients. It may be, for example, that a program which appears to be unsuccessful may actually be using an effective therapeutic approach, but they are trying to serve the wrong clientele with that particular technique.

Figure 1: Sample Portion of a PARTNERSHIP EVALUATION PLAN

VISION: Increase the ability of the target community to build and sustain a healthy environment for their families through a community empowerment model.
MISSION: Develop a true community partnership in which families, agencies, and schools work together as a team to design and deliver community-based, family focused services to meet the needs of overburdened families, thereby increasing their ability to cope with stressors and to increase their expectations for a positive future.

OBJECTIVES	ACTIVITIES	EXPECTED OUTCOMES	ASSESSMENT TOOLS
COMMUNITY-based Objectives/Outcomes			
Enhance and expand existing services to provide a nurturing community environment for healthy family and child development.	√ Hire staff for Partnership Program (Home Visitor, Community Coordinator, and Supervisor) to provide needed services to families in two target populations: ▪ families w/children 0-3 yrs ▪ families referred to Office of Family Services who are not at imminent risk. √ Work collaboratively with other community agencies to provide needed services to at-risk families in this service area.	√ New, unduplicated community services available to overburdened families in the target population. √ Identification of services needed by target families that are not currently available in this area. √ Creative outreach efforts to engage high risk families in the Partnership Program	√ baseline and program data regarding needed services and effectiveness of services currently available to families in the target populations. √ baseline/historical and post data on # and types of referrals to Office of Family Services for families served through the Partnership Program. √ family satisfaction questionnaire
FAMILY-based Objectives/Outcomes			
Educate family caregivers regarding healthy child development, appropriate expectations for their child(ren)'s behaviors, and appropriate methods of discipline.	√ Provide parenting classes offered community-wide. √ Home Visitors model and teach appropriate expectations for children √ Home Visitors model alternative methods of child discipline √ Budgeting and household management skills taught by Home Visitor. √ Make referrals for families where child development or behavioral problems are suspected.	√ Improved caregiver knowledge and appropriate expectations regarding child development. √ Use of appropriate methods of child discipline. √ Reduction of child abuse and neglect among families in the two target populations. √ Development of effective problem solving and coping skills √ Increased family self-sufficiency.	√ pre and post *Family Life Survey*: ▪ abuse potential subscale » child development expectations ▪ child risk factors subscale » parenting attitudes subscale » coping strategies subscale √ pre and post *Stress Factors Survey* and *Basic Needs Survey* √ pre and post *Family Assessment Form*, Section II: Caregivers
Provide appropriate support services (such as child care and transportation) to remove barriers to participation services and in family development activities.	√ Provide transportation and other appropriate support services to enable families to participate in Partnership and other community activities. √ Encourage and assist families to develop informal social support networks.	√ Appropriate utilization of social and health services for all family members √	√ pre and post *Family Life Survey*: » empowerment subscale ▪ coping strategies subscale ▪ coping strategies subscale √ family case record data on length and duration of services and financial assistance provided to families through the Partnership Program.

SECTION III: RESEARCH METHODS

In developing the Partnership Project evaluation process and assessment tools, one of the first tasks undertaken by *Trankel Research & Analysis* was an in-depth literature review to analyze the different assessment forms and tools used in child abuse prevention programs throughout the country. The result of this review was development of a catalog containing an abstract summary of information on the reliability and validity of over 75 different assessment tools.

The Partnership Project family surveys were developed specifically to measure the risk and resiliency factors most commonly associated with child abuse and neglect. TRA first chose items from several different scales in common usage as outcome measures for programs providing services similar to those of the Partnership Project. These items were placed into subscales that seemed to measure the relevant risk factors, based upon their ***face validity***. A total of 361 original items were selected by this method. The items were then placed in a survey sent to all staff involved in the startup phase of the Partnership Project. These persons were asked to act as a ***peer review panel***, by selecting items they felt were most appropriate as outcome measures related to the overall Partnership Project goals and objectives. Through this method, just over half of the original 361 items were discarded.

As a result of the peer review process, three family self-report surveys were developed for use in the Partnership Project evaluation: **PSF-20: Family Life Survey (FLS)**, which contains 151 items measuring 11 subscales; the **PSF-21: Life Experiences Survey (LES)**, with 12 items measuring 3 subscales; and the **PSF-22: Basic Needs/Stress Factors Survey (BN)**, which includes 15 basic needs items (with an additional 16 stress factors available on an *optional* longer version of the form, PSF-23). The three survey forms contain a total of 180 scale items. It should be noted that the two outcome measures most commonly utilized in evaluation of programs similar to the Partnership Project each contain a large number of total items, and neither of these assessment tools covers all of the risk and resiliency factors related to child abuse and neglect.[3]

The following is a description of the factors these Partnership Project scales developed by TRA were designed to measure:

PSF-20: Family Life Survey

Abuse Potential - measures caregiver attitudes toward use of physical control or punishment of their children, as well as the parent's perceived ability to control their own actions in the face of stress [14 items].

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[3] The most commonly used and recommended assessment instruments are the *Child Abuse Potential Inventory (CAP)*, which contains 160 items; and the *Parenting Stress Index (PSI)*, which contains 120 items. The forms derived for the Partnership Project include 26 items from the CAP, and 26 items from the PSI.

Child Development Knowledge - measures realistic and unrealistic expectations regarding tasks children should be able to perform at developmental stages of age 5 and under [11 items].

Child Risk Factors - measures caregiver perceptions regarding characteristics of their children that make the task of parenting more challenging or stressful, such as an especially difficult or nonresponsive child [15 items].

Coping Strategies - asks questions regarding the caregiver's typical style of handling problems and managing life stresses [9 items].

Depression/Unhappiness - measures the caregiver's perceptions of the relative happiness or unhappiness of their current life situation [13 items].

Domestic Violence - items designed to highlight a potentially abusive situation between the caregiver and her/his current significant other [3 items].

Empowerment - measure of the skills, esteem, and acceptance of responsibility necessary to make decisions, carry out plans, and effect change; self-motivation and ability to control one's own actions without being affected by external factors (*internal locus of control*); a sense that the individual does have control over their own life, and they actually attempt to exert such control [25 items].

Family Interaction Style - measures the caregiver's satisfaction with the amount and type of interactions that typically occur among family members, including positive and negative ways in which the family typically functions when faced with problems [14 items].

Parenting Attitudes - measures the caregiver's perceptions of their own ability to handle the demands of parenting, with some scale items designed to highlight a potential lack of bonding between parent and child [16 items].

Self-Esteem/Ego Strength - includes Rosenberg's classic self-esteem scale, which measures acceptance of self; additional items designed to measure the respondent's perceptions of their own psychological strength and self-worth [16 items].

Social Support Systems - items designed to tap the availability or lack of personal social support systems in the caregiver's life [15 items].

PSF-21: Life Experiences Survey

Parent's History of Being Physically Abused - questions taken from a national survey of a random sample of adults, with items designed to determine whether the respondent was physically abused by their caregiver(s) while growing up [5 items].

Parent's History of Being Sexually Abused - questions taken from a national survey of a random sample of adults, with items designed to determine whether the respondent was sexually abused by anyone while growing up [4 items].

Parent's History of Substance Abuse - questions routinely asked by physicians to determine whether their patient has a potential substance abuse problem [5 items].

PSF-22: Basic Needs/Stress Factors Survey

Basic Needs - questions designed to determine whether the family's basic needs for food, clothing, and shelter are being adequately met [15 items].

Basic Needs/Stress Factors (optional longer form) - this longer form includes the same 15 items from the Basic Needs survey (above), with additional items added to determine whether the family is experiencing other stresses that are not conducive to a healthy family living environment [16 additional items].

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Use of the above family self-report surveys at both ***pre-test*** and ***post-test*** points in time will serve three different purposes:

1) produce valid and reliable data for in-depth assessment of the level of potential risk for families receiving Partnership services;
2) provide a means of verifying the family risk factors reported by referral agencies; and
3) provide baseline and post-service data that will allow assessment of whether or not change has occurred among clients receiving Partnership services.

Statistical analysis of the data collected to date will continue throughout the next year of the Partnership Project. In addition to evaluating the family survey pre-tests, efforts are underway to establish the reliability and validity of these derived tools, and to develop standardized scores for the scales described above. This part of the analysis must be completed before reliable conclusions can be drawn from the data. By the time the 1996 Year-End Evaluation Report is due, this initial reliability/validity testing will be completed, and there will be enough post-tests available to allow analysis of the outcome measures and risk factors.

This 1995 Year-End Evaluation Report includes a demographic profile of Partnership families being served in two large Partnership Projects, as well as a listing of the risk factors most common among those families, as reported by the referring agencies. The two sites represented in **Appendix B** are: 1) ***Billings/Yellowstone County***, a large urban site; and 2) ***Libby***, a large rural site.

A thorough program assessment should also include documentation in sufficient detail to allow supervisors to effectively monitor worker and family progress. It should include a detailed accounting of how programs: a) established goals; b) selected staff; and c) determined program content and focus. These elements are part of a *process evaluation*, as contrasted with the *outcome evaluation* described above. The purpose of such documentation is to produce information in sufficient detail that successful programs can be replicated in similar environments.

All Partnership Project supervisors have been submitting quarterly reports describing the program as it has evolved at their site. In these reports, they describe their staffing patterns, interactions with community agencies providing similar support services, efforts to promote the program in the community and to seek appropriate referrals to the program, procedures used to screen and accept families into the Partnership Program, barriers encountered, and tactics utilized to overcome barriers and implement a successful program.

As part of the overall evaluation process, two different sets of interviews were conducted by Kate Mrgudic, Partnership Project State Coordinator, between July and December, 1995. One set of interviews was targeted to solicit input from Partnership Project home visiting staff, and the other focused on Partnership Project supervisors, directors and community collaborators. Two separate interview instruments were designed to elicit information on the respondents' experiences and perceptions regarding their particular involvement with the Project. The two broad topics of interest in this exploratory study were *best practices* for family support programs, and the *effectiveness of collaboration efforts*. Copies of these instruments appear in **Appendix C**.

The research on best practice information for family support programs indicated that successful programs have common characteristics. These include strong supervision of staff, manageable caseloads, adequate pre-service training, and ongoing in-service training. The *Questions for Family Support Specialists* interview instrument asked for staff feedback on these topics, as well as what they considered the most important and least important functions related to working with client families and with other agencies. Respondents were asked to identify strengths, problems, and improvements they had observed during this first start-up year of the Project, both for their own roles in the system and for the service delivery system as a whole. Additional questions were geared toward discovering what collaborative methods have been most and least effective in coordinating services with other agencies in their communities, what barriers have surfaced, and what attempts have been made to address those barriers. They were asked to elaborate on the same types of questions with regard to their work with families, and to make recommendations for improving the service system.

Because the Partnership Project mission and goals emphasized coordinated community involvement in the design, implementation and ongoing evaluation of project activities, the state wanted to assess the strengths and weaknesses of the local community collaboration

process. The research on community collaboration suggests that strong leadership, skilled meeting conveners, and local ability to resolve governance issues are key to successful collaboration projects. The *Questions for Community Liaisons and Partnership Project Supervisors* interview instrument asked for feedback on the following issues: definitions of prevention vs. intervention, and how the two types of services differ in practice; whether their site's Partnership Project goals have changed from the original design and if so, how and why; what strategies for linkages and collaboration have worked; what barriers have surfaced and how were they overcome; how were decisions made with regard to which referrals were considered appropriate for acceptance into the program; what services have families seemed most interested in; what is the respondent's perception of the impact of the Partnership Project within their community; and what services appear to be most effective for prevention and for building family strengths.

Communities where interviews have been conducted to date include the following: Granite County, Libby-Troy, Eureka, Missoula County, Dawson County, Richland County, Custer County, Valley County, Yellowstone County, Bozeman, Hill and Blaine Counties, and Beaverhead and Madison Counties. All interview responses were tape recorded and have been transcribed. Transcripts are currently being checked for accuracy against the recordings.

The analysis of such ***qualitative*** (narrative) data is lengthy and tedious. The next steps will involve identifying general themes in the information gathered. Similar comments will then be coded into the appropriate categories with the aid of a computer software program designed to assist in the analysis of qualitative data. This will allow the researchers to print out and examine the commonalities in issues across programs in the state. In conjunction with the State Partnership Project Coordinator, the Evaluation Contractor and a Master's Level Research Associate with experience in qualitative data analysis will prepare a report summarizing these issues and making recommendations for future planning and coordination efforts.

In addition, an individual assessment survey was completed by several of the interview subjects. This survey asked participants to rate their own strengths and weaknesses in several areas related to leadership and program supervision. This information will be tabulated and used in 1996 to plan and implement staff training programs.

Copies of these research instruments are attached in **Appendix C.**

PARTNERSHIP SITE DESCRIPTIONS

Region #: 1
Region: Eastern Montana
Site: Glasgow
County: Valley
Contractor: Valley Co. Health Department/Hi-Line Home Program
Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $25,000.00
Budget FY 95-96 : $30,050.00
Target Population: Prenatal - 5
Target # of Families : 20

- [ ] **PSF**
- [ ] **FS/FP**
- [x] **CC Type :** Crisis care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 13
 # Families Enrolled 94-95 : 10
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 10

Agencies Involved : Valley County Health Dept received the FY 94-95 contract. Hi-Line Home Program assumed the contract for FY 95-96

Staffing : 1.0 FTE Home Visitor
Supervision provided by Contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 1
Region: Eastern Montana
Site: Glendive
County: Dawson
Contractor: Dawson County Health Department
Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $25,000.00
Budget FY 95-96 : $33,000.00
Target Population: Prenatal - 5
Target # of Families : 25

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 11
 # Families Enrolled 94-95 : 7
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 10

Agencies Involved :

Staffing :
1.0 FTE Home Visitor
Supervision provided by Contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 1
Region: Eastern Montana
Site: Miles City
County: Custer
Contractor: Developmental Educational Assistance Program (DEAP)

Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $25,000.00
Budget FY 95-96 : $33,750.00
Target Population: Prenatal - 5
Target # of Families : 25

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 18
 # Families Enrolled 94-95 : 8
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 10

Agencies Involved :
Staffing : 1.0 FTE Home Visitor
Supervision provided by Contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 1
Region: Eastern Montana
Site: Sidney
County: Richland
Contractor: Hi-Line Home Programs, Inc.
Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $25,000.00
Budget FY 95-96 : $33,500.00
Target Population: Prenatal - 5
Target # of Families : 15

- [ ] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 19
 # Families Enrolled 94-95 : 11
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 10

Agencies Involved :

Staffing :
1.0 FTE Home Visitor
Supervision provided by Contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 2
Region: North Central Montana
Site: Great Falls
County: Cascade
Contractor: Opportunities, Inc.
Service Start Date: 7/1/95
Contract End: 7/1/96
Budget FY 94-95 :
Budget FY 95-96 : $35,000.00
Target Population: Prenatal - 3
Target # of Families : 15

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 12
 # Families Enrolled 94-95 : 12
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 12

Agencies Involved : Opportunities, Inc., Cascade County Child Abuse Prevention Council, Families Count, Young Parent Education Center, St. Thomas Child Development Center

Staffing : .5 FTE Family Support Worker .25 FTE Project Coordinator

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 2
Region: North Central Montana
Site: Havre,Chinook, Rocky Boy & Ft Belknap Reservations
County: Hill; Blaine
Contractor: Human Resource Development Council
Service Start Date: 11/1/94
Contract End: 6/30/96
Budget FY 94-95 : $172,170.00
Budget FY 95-96 : $172,170.00
Target Population: Prenatal - 5
Target # of Families : 80

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 90
 # Families Enrolled 94-95 : 82
 # Family Workers : 5
FTE Workers : 5
Avg Caseload Size : 20

Agencies Involved : HRDC, Blaine County Health Dept., Rocky Boy Tribal Social Services, Ft. Belknap Tribal Social Services.

Staffing : 4 FTE Home Visitors (1 in Hill County, 1 in Blaine County, 1 at Rocky Boy Reservation, 1 at Ft. Belknap Reservation.)
1 FTE Project Manager/Supervisor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family; and
9) establishing formal commitments and systems of referral from agencies providing services to at-risk families.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 3
Region: South Central Montana
Site: Billings
County: Yellowstone
Contractor: Family Support Network
Service Start Date: 12/1/95
Contract End: 8/31/96
Budget FY 94-95 : $115,317.00
Budget FY 95-96 : $133,400.00
Target Population: Prenatal - 3, referred to CFS
Target # of Families : 45

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 70
 # Families Enrolled 94-95 : 43
 # Family Workers : 4
FTE Workers : 3
Avg Caseload Size : 15

Agencies Involved :

Staffing :
2 FTE Home Visitors
2 .5 FTE Home Visitors
1 .5 FTE Supervisor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family; and
9) providing neighborhood support groups in three high-risk neighborhoods in Billings.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 3
Region: South Central Montana
Site: Billings
County: Yellowstone
Contractor: The Family Tree
Service Start Date: 2/1/95
Contract End: 8/31/96
Budget FY 94-95 : $6,570.00
Budget FY 95-96 : $56,711.00
Target Population: Prenatal - 3
Target # of Families : 32

- [x] **PSF**
- [ ] **FS/FP**
- [ ] **CC Type :**
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 24
 # Families Enrolled 94-95 : 24
 # Family Workers : 2
FTE Workers : 2
Avg Caseload Size : 12

Agencies Involved :

Staffing :
1 Home Visitor
.15 Contract Supervisor
Parent Education Facilitators

Description of Services:

Intensive home visiting to high risk families at the birth of children, in conjunction with Yellowstone City-County Health Department, and St. Vincent's Hospital and Health Center; and Parent education classes.
Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e., aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family; and
9) providing neighborhood support groups in three high-risk neighborhoods in Billings.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 3
Region: South Central Montana
Site: Billings
County: Yellowstone
Contractor: Young Families Program
Service Start Date: 12/20/94
Contract End: 8/31/96
Budget FY 94-95 : $13,140.00
Budget FY 95-96 : $6,570.00
Target Population: Prenatal - 3
Target # of Families : 30

- [x] PSF
- [ ] FS/FP
- [ ] CC Type :
- [ ] FBS
- [ ] SG
- [ ] FFK

 # Families Referred 94-95 : 25
 # Families Enrolled 94-95 : 25
 # Family Workers :
FTE Workers :
Avg Caseload Size :

Agencies Involved :
Staffing : 2 Group Facilitators

Description of Services:

Provide parent support/education groups for:
1) prenatal/birth parents; and
2) teen parents with children under 3 years of age.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 4
Region: Southwest Montana
Site: Anaconda
County: Deer Lodge
Contractor: Anaconda PCA "Family Enrichment" Council
Service Start Date: 11/1/94
Contract End: 8/31/96
Budget FY 94-95 : $50,000.00
Budget FY 95-96 : $50,000.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 25

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis day care center
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 43
 # Families Enrolled 94-95 : 21
 # Family Workers : 2
FTE Workers : 2
Avg Caseload Size : 10

Agencies Involved :

Staffing :

.75 FTE Family Resource Coordinator
.75 FTE In Home Skill Builder
Life Skills Facilitator (7 sessions/month)
Supervision provided jointly by Contractor and Deer Lodge County Health Department

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

PCA Care Nursery served 197 children in 6 months.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 4
Region: Southwest Montana
Site: Bozeman
County: Gallatin
Contractor: Gallatin City-County Health Department
Service Start Date: 1/1/95
Contract End: 6/30/95
Budget FY 94-95 : $55,000.00
Budget FY 95-96 : $100,000.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 15

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC Type :**
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 29
 # Families Enrolled 94-95 : 14
 # Family Workers : 3
FTE Workers : 2
Avg Caseload Size : 9

Agencies Involved : Monforton School; Prevent Child Abuse, Inc.; Bozeman Public Alternative Schools; Gallatin City-County Health Dept.; HRDC; Gallatin County Prevention Coalition;

Staffing :
0.6 FTE Social Worker
1 FTE Family Support Worker through Prevent Child Abuse, Inc., supervision provided by PCA.
Contracts for service coordination, child care for teen parents in school, activities for children's families.

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family.
9) providing child care, education support, and scholarships to teen parents through Alternative High School Program; and
10) providing recreation opportunities, transportation, activity supplies, and child care through Monforton School.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 4
Region: Southwest Montana
Site: Deer Lodge
County: Powell
Contractor: Child Start, Inc.
Service Start Date: 2/1/95
Contract End: 8/31/96
Budget FY 94-95 : $25,300.00
Budget FY 95-96 : $26,300.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 25

- [x] **PSF**
- [ ] **FS/FP**
- [ ] **CC Type :**
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 10
 # Families Enrolled 94-95 : 10
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 10

Agencies Involved :

Staffing : .75 FTE Family Resource Director/Home Visitor
Supervision provided by contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family; and
9) providing day care to families to attend parent education programs.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 4
Region: Southwest Montana
Site: Dillon
County: Beaverhead; Madison
Contractor: Women's Resource Center
Service Start Date: 2/1/95
Contract End: 6/30/96
Budget FY 94-95 : $50,000.00
Budget FY 95-96 : $74,136.00
Target Population: Prenatal-5 & referred to CFS
Target # of Families : 30

- [x] **PSF**
- [ ] **FS/FP**
- [ ] **CC Type :**
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 30
 # Families Enrolled 94-95 : 25
 # Family Workers : 4
FTE Workers : 2
Avg Caseload Size : 7

Agencies Involved : DPHHS; WORKS; Mental Health/Managing Resources Montana; Barrett Hospital Social Services; Beaverhead County Health Dept.; Women's Resource Center, Schools, New Options.

Staffing :
4 .5 FTE Home Visitors
.5 Supervisor/Coordinator

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family;
9) establishing prevention services in day care center; and
10) providing day care to families to attend parent education programs.

Madison County-13 families; 2 workers at 10 hours/wk
Beaverhead County-8 families; 2 workers at 10 hours/wk

PARTNERSHIP SITE DESCRIPTIONS

Region #: 4
Region: Southwest Montana
Site: Granite County
County: Granite
Contractor: Child Start, Inc.
Service Start Date: 2/1/95
Contract End: 8/31/96
Budget FY 94-95 : $24,700.00
Budget FY 95-96 : $24,700.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 15

- [x] **PSF**
- [ ] **FS/FP**
- [ ] **CC Type :**
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 6
 # Families Enrolled 94-95 : 4
 # Family Workers : 1
FTE Workers : 1
Avg Caseload Size : 6

Agencies Involved :

Staffing :

.25 FTE Daycare Director
.50 FTE Family Resource Director/Home Visitor
Supervision provided by contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family;
9) establishing prevention services in day care center; and
10) providing day care to families to attend parent education programs.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 5
Region: Western Montana
Site: Eureka
County: Lincoln
Contractor: Nurturing Center
Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $30,831.00
Budget FY 95-96 : $41,107.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 24

- [x] PSF
- [ ] FS/FP
- [x] CC Type :
- [ ] FBS
- [ ] SG
- [ ] FFK

 # Families Referred 94-95 : 15
 # Families Enrolled 94-95 : 12
 # Family Workers : 3
FTE Workers : 2
Avg Caseload Size : 4

Agencies Involved :

Staffing :

.75 FTE Therapeutic Home Visitor
.25 FTE Therapeutic Home Visitor
1 FTE Home visitor Supervision provided by Contractor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family;
9) increasing coordination in community support options and in community services available to families;
10) providing parent education classes; and
11) providing day care for parenting classes and respite day care.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 5
Region: Western Montana
Site: Libby/Troy
County: Lincoln
Contractor: Lincoln County Champion Group Home
Service Start Date: 12/1/94
Contract End: 6/30/96
Budget FY 94-95 : $146,458.00
Budget FY 95-96 : $198,854.00
Target Population: Prenatal - 3 & referred to CFS
Target # of Families : 50

- [x] **PSF**
- [ ] **FS/FP**
- [x] **CC** **Type :** Crisis Care
- [ ] **FBS**
- [ ] **SG**
- [ ] **FFK**

 # Families Referred 94-95 : 49
 # Families Enrolled 94-95 : 45
 # Family Workers : 5
FTE Workers : 5
Avg Caseload Size : 9

Agencies Involved : Lifelinks--8 clients

Staffing : 4.5 FTE Home visitors .5 FTE Community coordinator
.5 FTE Supervisor

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:

1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary;
8) transporting or arranging for transporting the family;
9) increasing coordination in community support options and in community services available to families;
10) providing parent education classes; and
11) providing day care for parenting classes and respite day care.

PARTNERSHIP SITE DESCRIPTIONS

Region #: 5
Region: Western Montana
Site: Missoula
County: Missoula
Contractor: Missoula County
Service Start Date: 1/1/95
Contract End: 6/30/96
Budget FY 94-95 : $72,036.00
Budget FY 95-96 : $134,000.00
Target Population: Prenatal - 3
Target # of Families : 125

- [x] PSF
- [ ] FS/FP
- [ ] CC Type :
- [ ] FBS
- [ ] SG
- [ ] FFK

 # Families Referred 94-95 : 90
 # Families Enrolled 94-95 : 63
 # Family Workers : 5
FTE Workers : 3
Avg Caseload Size : 8

Agencies Involved :

Staffing : Subcontracts with Missoula City-County Public Health, Futures, Child Care Resources, Child and Family Resource Council.
.5 FTE Coordinator

Description of Services:

Provide a wide range of goal-directed services to families, including but not limited to:
1) teaching appropriate parenting skills;
2) family and individual communication skill-building;
3) teaching budgeting skills;
4) aiding the family in meeting medical needs, such as arranging for substance abuse treatment for family members, immunizations for children, etc., and making follow-up support resources available;
5) teaching the family housekeeping, homemaking and other organizational skills needed to provide a positive environment (e.g., modeling behavior such as assisting the family to clean the home);
6) referring and linking the family with needed concrete services (i.e. aiding the family in obtaining furniture, beds, etc.);
7) referring and linking the family with follow-up services when necessary; and
8) transporting or arranging for transporting the family.

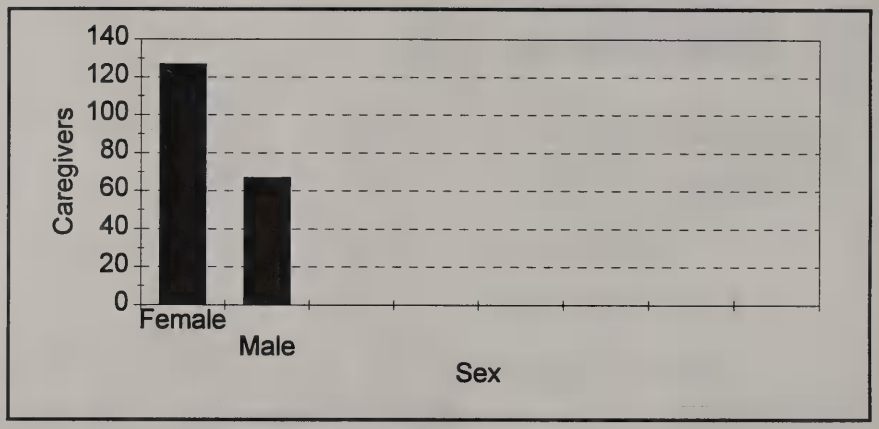
Intensive home visiting to 30 families through Missoula Health Department; intensive case management to 7 teen mothers through Futures; parent education (Nurturing Program), respite services, and library resource materials.

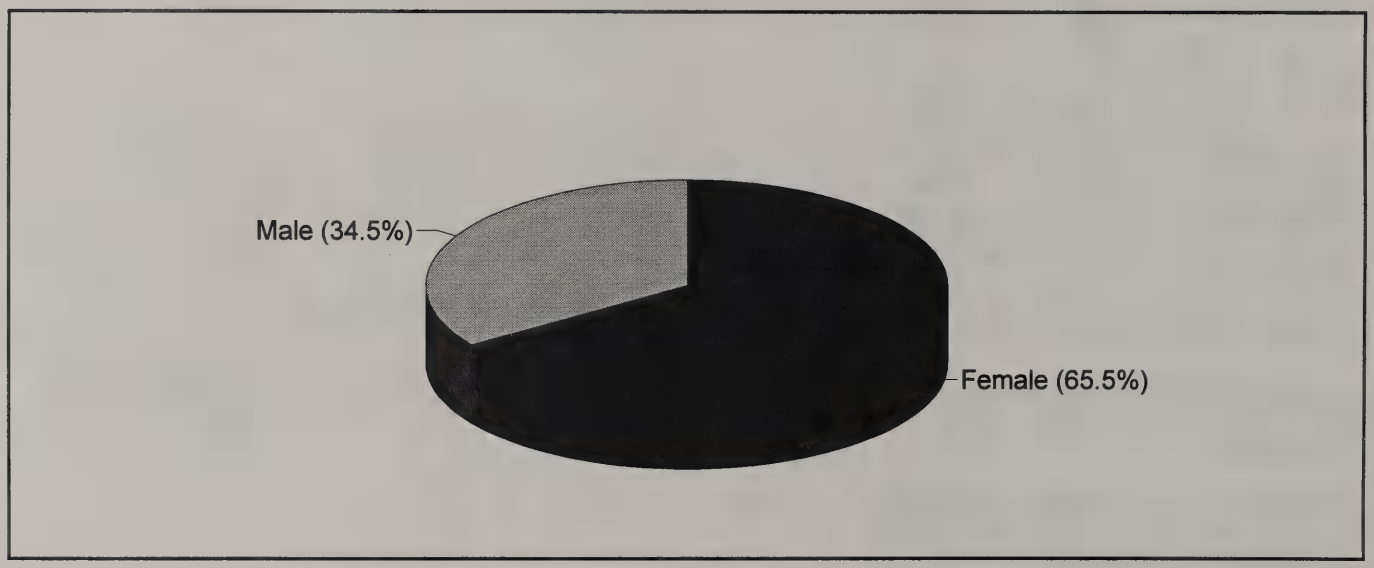
Missoula County Health Department – 27 families
Child and Family Resource Council -- 21 families
Futures -- 15 families

Demographic Information
GENDER - Caregivers

Service Area : **Billings**

Gender	Caregivers
Female	127
Male	67
Total :	194
Missing Values :	0



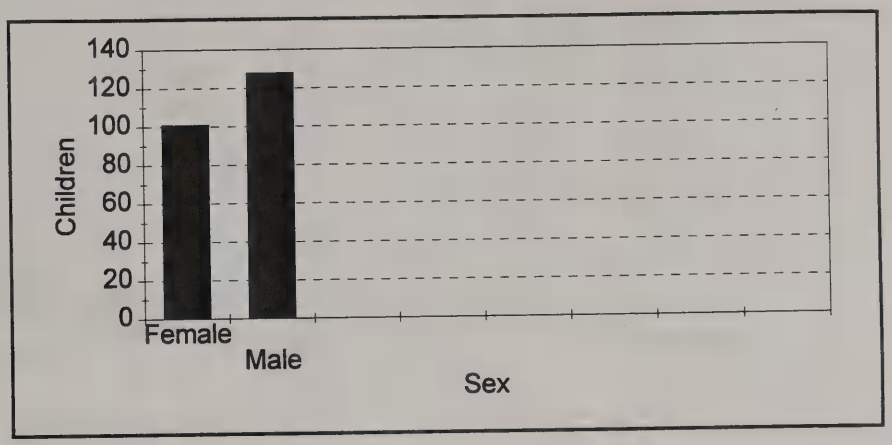


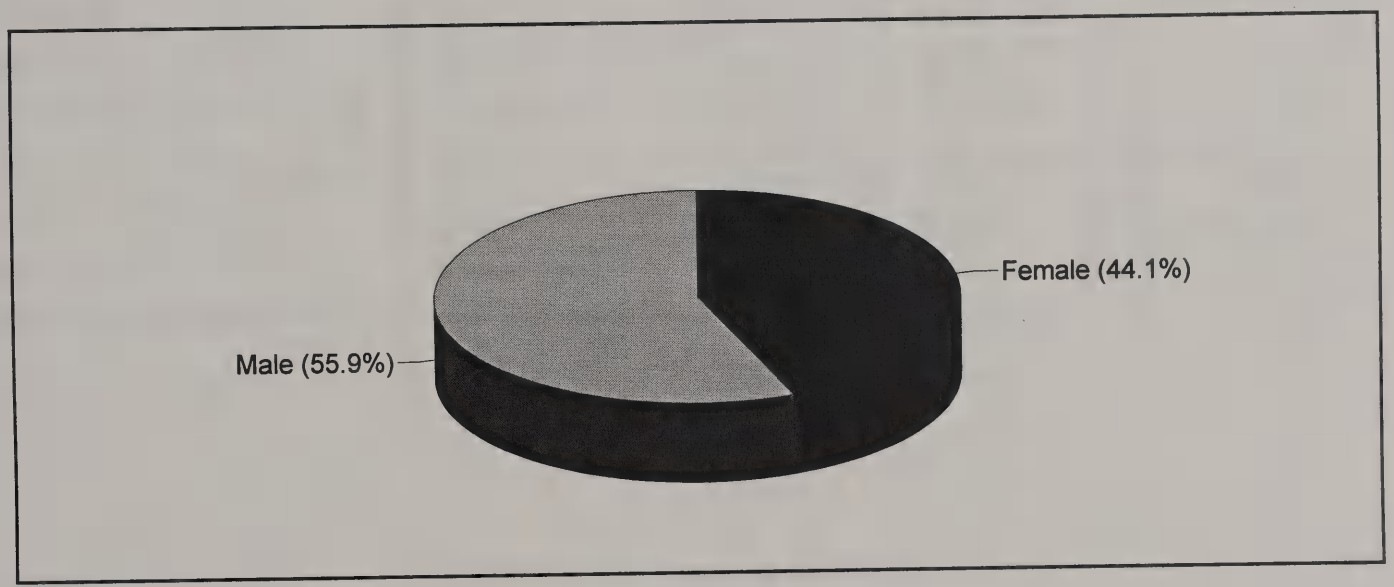
Demographic Information
GENDER - Children

Service Area : **Billings**

Gender	Children
Female	101
Male	128
Total :	229

LABEL

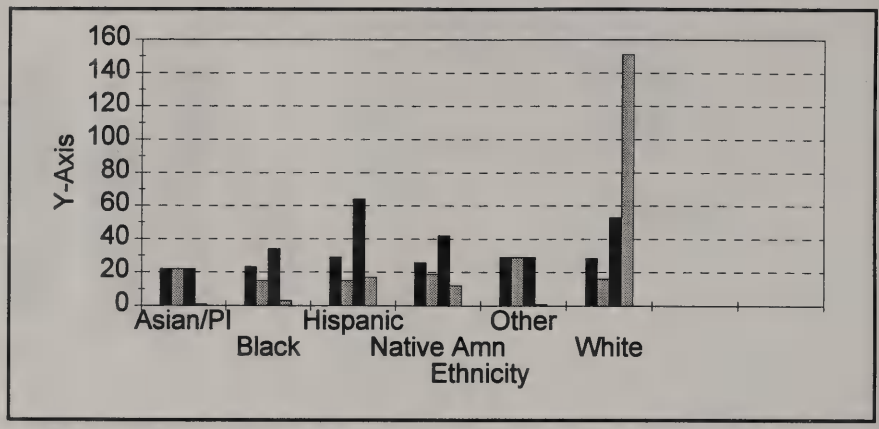




Demographic Information
RACE and AGE - Caregivers

Service Area : **Billings**

Ethnicity	Total
Asian/PI	1
Black	3
Hispanic	17
Native Amn	12
Other	1
White	151
Total :	185
Missing Values :	9



	Average Age
Asian/PI	22
Black	23.33
Hispanic	29.13
Native Amn	25.75
Other	29
White	28.54

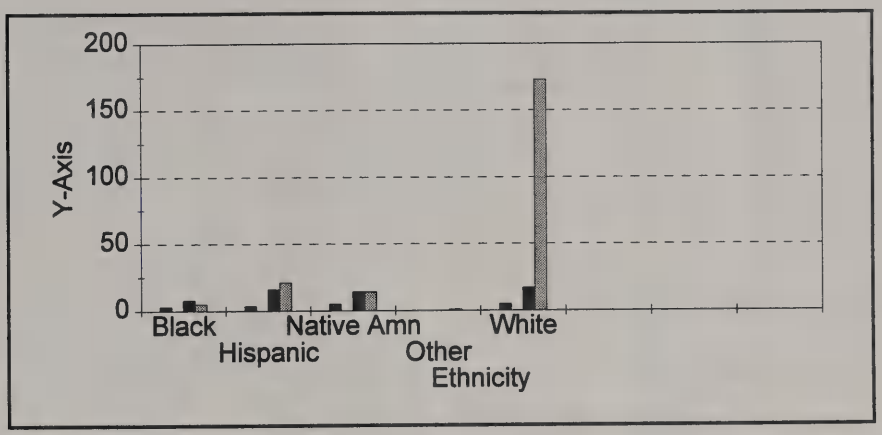
	Minimum Age
Asian/PI	22
Black	15
Hispanic	15
Native Amn	19
Other	29
White	16

	Maximum Age
Asian/PI	22
Black	34
Hispanic	64
Native Amn	42
Other	29
White	53

Demographic Information
RACE and AGE - Children

Service Area : **Billings**

Ethnicity	Total
Black	5
Hispanic	21
Native Amn	14
Other	1
White	173
Total :	214
Missing Values :	19



	Average Age
Black	3.2
Hispanic	3.57
Native Amn	4.93
Other	0
White	4.92

	Minimum Age
Black	0
Hispanic	0
Native Amn	0
Other	0
White	0

	Maximum Age
Black	8
Hispanic	16
Native Amn	14
Other	0
White	17

FAMILY RISK FACTORS
Listed in Descending Order by Frequency

Service Area : **Billings**

Risk Factor	Total
Poor Parenting Skills	78
Poverty Level Income	76
Social Isolation	67
Caregiver Abused as Child	62
Emotional/Mental Illness	57
Substance Abuse	42
Inadequate Housing	41
Other Risk Factor	41
Difficult Child	39
Basic Needs Not Met	37
Domestic Abuse Potential	35
Less than HS Education	34
Lack of Prenatal Care	28
Physical Abuse of Child	21
Sexual Abuse	10
Physical Neglect of Child	0

SAMPLE PAGE

LOG of SERVICES/ACTIVITIES by Funding Source

Fund Cd : PP **Funding Source :** Partnership Project

Family ID	Service Date	Adult	Child	Log Cd	Service/Activity	Minutes	Amount
[redacted]	5/8/95	Lisa		12	Service Coord/Case Mngmt	15	
[redacted]	5/9/95	Lisa		12	Service Coord/Case Mngmt	60	
[redacted]	5/15/95	Lisa		4	Advocacy/Mentoring	60	
[redacted]	5/16/95	Lisa		12	Service Coord/Case Mngmt	30	
[redacted]	5/22/95	Lisa		10	Referrals to Community Services	30	
[redacted]	5/24/95	Lisa		10	Referrals to Community Services	15	
[redacted]	5/30/95	Lisa		10	Referrals to Community Services	45	
[redacted]	6/5/95	Lisa		4	Advocacy/Mentoring	60	
[redacted]	6/12/95	Lisa		4	Advocacy/Mentoring	15	
[redacted]	6/19/95	Lisa		25	Housing Assistance	60	
[redacted]	6/26/95	Lisa		4	Advocacy/Mentoring	60	
[redacted]	7/2/95	Lisa		12	Service Coord/Case Mngmt	15	
[redacted]	7/11/95	Lisa		12	Service Coord/Case Mngmt	30	
[redacted]	7/31/95	Lisa		12	Service Coord/Case Mngmt	5	
[redacted]	8/2/95	Lisa		1	Assessment	80	
[redacted]	8/8/95	Lisa		1	Assessment	30	
[redacted]	8/8/95	Lisa		4	Advocacy/Mentoring	40	
[redacted]	8/10/95	Lisa		11	Support Empowerment	30	
[redacted]	8/15/95	Lisa		14	Support Group	120	
[redacted]	8/16/95	Lisa		12	Service Coord/Case Mngmt	20	
[redacted]	8/22/95	Lisa		14	Support Group	120	
[redacted]	8/23/95	Lisa		1	Assessment	30	
[redacted]	8/24/95	Lisa		12	Service Coord/Case Mngmt	20	
[redacted]	8/24/95	Lisa		21	Stress/Coping Skills	60	
[redacted]	8/29/95	Lisa		12	Service Coord/Case Mngmt	10	
[redacted]	8/29/95	Lisa		14	Support Group	120	
[redacted]	8/29/95	Lisa		16	Transportation/Access to Services	90	
[redacted]	8/30/95	Lisa		20	Problem Solving Skills	60	
[redacted]	9/5/95	Lisa		11	Support Empowerment	60	
[redacted]	9/7/95	Lisa		11	Support Empowerment	60	
[redacted]	9/12/95	Lisa		11	Support Empowerment	30	
[redacted]	9/14/95	Lisa		11	Support Empowerment	60	
[redacted]	9/14/95	Lisa		20	Problem Solving Skills	90	
[redacted]	9/19/95	Lisa		12	Service Coord/Case Mngmt	60	
[redacted]	9/19/95	Lisa		38	Respite Child Care (planned)	60	
[redacted]	9/22/95	Lisa		12	Service Coord/Case Mngmt	20	
[redacted]	9/25/95	Lisa		11	Support Empowerment	60	
[redacted]	9/28/95	Lisa		11	Support Empowerment	60	
[redacted]	10/3/95	Lisa		11	Support Empowerment	60	
[redacted]	10/9/95	Lisa		11	Support Empowerment	60	
[redacted]	10/9/95	Lisa		12	Service Coord/Case Mngmt	10	
[redacted]	10/13/95	Lisa		20	Problem Solving Skills	60	
[redacted]	10/18/95	Lisa		20	Problem Solving Skills	90	
[redacted]	10/23/95	Lisa		12	Service Coord/Case Mngmt	10	
[redacted]	10/27/95	Lisa		21	Stress/Coping Skills	90	
[redacted]	11/3/95	Lisa		4	Advocacy/Mentoring	60	
[redacted]	11/7/95	Lisa		12	Service Coord/Case Mngmt	10	
[redacted]	11/8/95	Lisa		4	Advocacy/Mentoring	90	
[redacted]	11/30/95	Lisa		4	Advocacy/Mentoring	60	
[redacted]	12/4/95	Lisa		21	Stress/Coping Skills	10	

QUESTIONS FOR:
FAMILY SUPPORT SPECIALISTS

1. What is the average size of your caseload?

2. What is your training/experience background? (Types of disciplines)

3. Is there pre-service or in-service training available for your position?

   If yes: Adequate? Helpful?

4. Is supervision of your position adequate?

5. Describe your role as Family Support Specialist.

6. Do you think the system leadership and agency administration share the same perception of the role and functions as the Family Support Specialists?

7. Is there adequate support for Family Support Specialists from the agency administration?

8. What are the most important functions of Family Support Specialists as related to:

   a) Working with families

   b) Working with other agencies

9. What are the least important functions of the Family Support Specialist as related to:

   a) Working with families

   b) Working with other agencies

10. Family Support Specialists in this system:

    a) Major strengths

    b) Major problems

    c) Ways in which it can be improved

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August 10, 1995

11. Describe the collaborative process among:

    a) Agency administrators

    b) Staff from various agencies

    c) Family Support Specialists from various agencies.

12. Which strategies are most productive for collaborative efforts.

13. As you work with the various agencies and providers within the system:

    a) Do you have sufficient authority to access services needed from the various child-serving agencies?

    b) How do you deal with conflict among agencies?

14. Which agencies are most effective at employing preventive strategies?

15. What barriers exist to working with families?

    a) Within families themselves?

    b) System-wide barriers?

    c) Interagency barriers?

16. What attempts have been made to address these barriers?

    Which were most effective?

    Which did not work? Why?

17. Most significant service gaps?

18. Major strengths of your service system?

19. What should priorities be for improvement?

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QUESTIONS FOR:
COMMUNITY LIAISONS/PARTNERSHIP PROJECT SUPERVISORS

1. How would you define prevention? Prevention services?

2. Do you see the intervention services as being different from prevention services?

   If so, how?

3. What were your original goals for this Partnership Project?

4. Have your goals changed? If so, how and why?

5. Have any of your specific prevention strategies changed over the past year?

   If so, how and why?

6. What strategies for linkages and collaboration have proven effective for enhancing prevention services?

7. What is your agency's relationship with the following programs or services:

   A) WIC nutritional services

   B) Child protective services

   C) Community-based child care services

   D) Health care providers?
   What specific health care programs are available in your community?

8. How were the community linkages formed?

9. What were the barriers to successful collaboration?

10. What strategies seemed to help overcome these barriers?

11. Can you give an example of how your program/agency collaborates with another to co-ordinate services for a family?

12. What are the policies and practices that apply?

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13. How would you define collaboration?

14. Do you feel your community could use additional technical assistance to enhance collaboration and linkage of community services?

15. Are there any other types of technical assistance that you feel would benefit your community?

16. What procedure does your agency/program follow in making or accepting referrals for the Partnership Project?

17. What services do families seem most interested in?

18. What has been the impact of the Partnership Project in your community?

19. What services do the family support specialists feel are the most effective:

    For prevention?

    For building family strengths?

VOLUNTEER COORDINATOR SKILLS SELF ASSESSMENT

NAME: _____
TITLE: _____

Please rate yourself on how you perceive your current skill level in the following areas:

PART I: LEADERSHIP SKILLS	SKILL LEVEL Weak <----------> Strong				
1. Ability to Vision	1	2	3	4	5
2. Building Coalitions & Partnerships	1	2	3	4	5
3. Building Consensus	1	2	3	4	5
4. Facilitating Meetings	1	2	3	4	5
5. Public Speaking	1	2	3	4	5
6. Conflict Resolution	1	2	3	4	5
7. Writing a Mission Statement	1	2	3	4	5
8. Setting Quantifiable Goals	1	2	3	4	5
9. Influencing Change (attitudinal, organizational, etc.)	1	2	3	4	5
10. Time Management	1	2	3	4	5
11. Creative Problem Solving	1	2	3	4	5
12. Openness to Diversity of Opinions	1	2	3	4	5
13. Patience	1	2	3	4	5
14. Listening	1	2	3	4	5
15. Giving Critical Feedback	1	2	3	4	5
16. Receiving Critical Feedback	1	2	3	4	5
17. Communicating Effectively (vision, ideas, plans)	1	2	3	4	5
18. Creating Strategies for Investment & Ownership	1	2	3	4	5

Other: (list leadership skills not covered above)

_____

_____

_____

_____

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August 10, 1995

NAME: _____

TITLE: _____

Please rate yourself on how you perceive your current skill level in the following areas:

PART II: PROGRAM MANAGEMENT SKILLS	SKILL LEVEL Weak <----------> Strong				
1. Conducting a Needs Assessment	1	2	3	4	5
2. Working with the Media	1	2	3	4	5
3. Program Planning	1	2	3	4	5
4. Memo & Report Writing	1	2	3	4	5
5. Developing Staff Positions	1	2	3	4	5
6. Recruiting Staff & Community Outreach	1	2	3	4	5
7. Interviewing Staff	1	2	3	4	5
8. Developing & Conducting Orientations & Trainings	1	2	3	4	5
9. Developing Manuals, Handbooks & Brochures	1	2	3	4	5
10. Supervision/Motivation of Staff	1	2	3	4	5
11. Recognition of Staff	1	2	3	4	5
12. Data Collection and Analysis	1	2	3	4	5
13. Budgeting	1	2	3	4	5
14. Leveraging Resources	1	2	3	4	5
15. Grant/Proposal Writing	1	2	3	4	5

Other: (list program and management skills not covered above)

_____

_____

_____

_____

T E C H

B R I E F

Technical Assistance Brief

PROGRAM EVALUATION COMPONENTS

by Mary A. Trankel, Ph.D., *Trankel Research & Analysis*
Program Evaluation Contractor for
Montana Department of Public Health and Human Services
Office of Family Services

The purpose of this Technical Brief is to provide an overview of program evaluation procedures and data definitions that should be standardized for all family service providers in Montana in order to provide a coordinated assessment process.

ACRONYM Key:

DPHHS = MT Dept of Family Health and Human Services
EID = Early Identification Worker
FBS = Family Based Services
FSW = Family Support Worker
HFA = Healthy Families America
HS = Healthy Start Program
PHN = Public Health Nurse
PSF = DPHHS Partnership to Strengthen Families Project
TRA = Trankel Research & Analysis, Evaluation Contractor

As a means of organizing this discussion on evaluation procedures, ***Trankel Research & Analysis*** **(TRA)**, Evaluation Contractor for DPHHS, has used a summary of research components recommended by *Healthy Families America* (HFA) for a comprehensive evaluation of family intervention programs. HFA is an initiative formed by the *National Committee to Prevent Child Abuse* (NCPCA), in partnership with *Ronald McDonald Children's Charities* (RMCC). This organization was established to provide technical assistance to communities planning intensive prevention services for at-risk families. The recommendations offered by HFA are based upon two decades of research, as well as specific knowledge gained from evaluating the Hawaii *Healthy Start* (HS) Program.

The discussion on the following pages is divided into three columns. In the left column are recommendations made by *Healthy Families America* and/or procedures common to the Hawaii *Healthy Start* Program. These are designated with a superscript ^{HFA} or ^{HS} notation, respectively. Below each recommendation, TRA provides a short explanation of the rationale for that research component. The middle column contains comments by TRA regarding the appropriateness of each procedure for Montana's DPHHS home based service projects.

The third column contains a list of questions that local program providers should ask themselves about how each specific research recommendation can be implemented for their program. In the shaded area at the bottom of column three we have listed the forms created by TRA to help gather the recommended research data. Prior to development of these data collection instruments, TRA conducted a comprehensive review of the literature on evaluation procedures and assessment tools used throughout the country to analyze home based family services. We reviewed over 75 different assessment tools and compiled a one-page synopsis for each tool that included the following information: name of the tool; developer; how the tool is administered; what the tool

measures (including number of total items and subscales); what groups of subjects the tool was used to assess; information about the reliability and validity of the tool.

Since no assessment instrument was available that would assess all of the risk and resiliency factors of interest to DPHHS, TRA developed the *Family Life Survey* (FLS), *Basic Needs Survey* (BN), and *Life Experiences Survey* (LES) by compiling appropriate subscale items from the standardized tools available. The original pool of over 450 items was then subjected to a panel review of family service providers in Montana. The resulting three survey instruments include a total of 178 items comprising 15 subscales designed to measure the following risk and resiliency factors: abuse potential; unrealistic child development expectations; child risk factors; coping strategies; depression or unhappiness; domestic abuse potential; personal empowerment; family interaction style; parenting attitudes; self-esteem or ego strength; family social support systems; whether the family's basic needs for food, clothing, shelter, and medical necessities are being met; caregiver's history of physical or sexual abuse during childhood; and caregiver's history of substance abuse.

Wherever you anticipate problems with the recommended procedures, TRA asks that you brainstorm with us or with co-workers to devise an alternate workable solution that will not compromise the integrity of the research process.

HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
1. Use a formal *control* or *comparison* group (similar families who did not receive the intervention). Subjects should be either:[HFA] a. *randomly assigned*; or b. *matched* in terms of age, race, income, risk of child abuse, and other relevant factors. RATIONALE: It is not enough to demonstrate change or improvement in the families who receive intervention services (the *treatment group*), since it could be argued that such change might have occurred by chance alone or simply through the process of growth over time. However, if it can be demonstrated that certain specific changes occurred in the *treatment group* but not in the *comparison group*, this provides much stronger evidence that the observed changes probably would not have occurred without the intervention services (since subjects in both groups would have experienced the same chance for growth due to passage of time). Subjects in both the treatment and comparison groups must be given the same types of assessment(s) in order to produce appropriate comparative data. As *Healthy Start* evaluator Loretta Fuddy has noted, *the more you say your program is successful, the greater scrutiny you will receive about the methods used to document success.*	It is not likely that project staff will be willing or able to use a true *control group* of families who are randomly assigned to treatment and non-treatment groups. For example, there are ethical concerns with regard to depriving services to a family considered to be at-risk for abusing their child in order to randomly assign them to a "no service" control group. It is also difficult to solicit someone's participation in an innovative new program, and then ask them to serve as a member of the "no-service" study group. A more reasonable solution may be to identify a group of subjects who can be *matched* with families receiving service, such as: (1) persons eligible for services but who decline to participate in the program; (2) persons currently receiving community services of a similar type to those offered through the project; or (3) persons who wish to receive services but who must be placed on a waiting list due to staff limitations. Each of these alternatives presents a specific *threat to validity*. Some validity threats can be controlled for statistically, while others present a problem that cannot be easily solved. For example, it can be suspected that persons in comparison group (1) above would be substantially different from persons in the treatment group in terms of motivation to improve their caregiver skills. Thus, they would not constitute an adequate comparison group.	PLANNING DECISIONS: ▪ Is there a local group(s) of families, similar to the families you hope to serve, who could serve as a *comparison group*? ▪ How are these people similar to your potential families? ▪ In what ways might they be different from your potential families? Use of a comparison group is not requested by the statewide evaluation contractor at this time. Currrent evaluation procedures and forms must be further tested and refined. A lot of effort is involved in the startup of new evaluation procedures, and in rural areas of Montana it will be difficult to find appropriate local comparison groups. This nationally recommended evaluation procedure will be implemented at a later date, and will probably be pilot-tested at site(s) where there is staff capacity and easy access to an appropriate comparison group.

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HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
2. Use a range of different *outcome measures*. a. Three measures of caregiver change: ☒ use of informal & formal social supports ☒ use of health care services ☒ knowledge of parenting/child development ☒ attitudes twd/use of corporal punishment ☒ stress/coping strategies ☐ quality of caregiver-child interaction ☒ subsequent pregnancies ☐ educational achievement ☐ employment b) Two child-related measures ☐ infant mortality ☐ child's physical development ☐ child's cognitive (mental) development ☐ child's social functioning ☒ reports of child abuse and neglect ☒ demographic data on participants ☒ socio-economic data ☒ services offered to families ☒ services used by families (duration/intensity) RATIONALE: An evaluation should not measure outcomes solely in terms of subsequent reports of maltreatment. In deciding what types of measurement outcomes are appropriate, program staff should consider what types of attitudes and behaviors they can realistically expect to change; as well as how the expected outcomes can be related to a reduction in child abuse and neglect.	Regardless of whether a control or comparison group is utilized in an evaluation, it is important for each site to use a variety of different outcome measures. These measures or assessments must be administered at least twice (as a *pre-test* and a *post-test*) since, without establishing a *baseline* status for the family, it is not possible to demonstrate whether any change occurred. *Pre-tests* must be administered prior to any type of service intervention. Conducting even one home visit with a family may be enough to affect their sense of hope or self-confidence, and such changes would not be reflected in the post-test if the pre-test administration was delayed until the worker had a chance to establish rapport with the family. It is best to have potential families fill out any self-report forms at the time they enroll in the program -- either in an office setting or at the very beginning of the first home visit (after some general conversation to establish rapport but prior to an in-depth discussion of program services and benefits the family can expect to receive). While this may seem awkward and contrary to good social work practice, experience has shown that most people are generally cooperative and understand the necessity for such paperwork procedures if the rationale is explained to them in a logical, diplomatic fashion (e.g., *Our funding source requires us to gather certain statistical information. It is also important for us to understand your family and your priorities and concerns in order to offer services that you will find truly useful. All information you give us will be kept strictly confidential*).	PLANNING DECISIONS: • What are the different attitudes, behaviors, etc. that you hope to influence (change) in your families? [Try to think in terms of short, specific *concepts*, e.g., parenting knowledge, informal social supports, self-esteem, etc.] • Are there existing assessment instrument(s) that seem to be appropriate for measuring these concepts? • Who will administer each of the assessment instruments and when? ■ see checklist in column 1 for outcome measures incorporated into the following forms: ◘ *Family Life Survey* ◘ *Basic Family Needs* ◘ *Life Experiences Survey* ■ *Pre-test* forms should be completed no later than the second home visit (at least within 30 days for very hard-to-engage families). ■ Post-test forms should be completed within 30 days after terminating services.

HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
3. Use multiple methods of data collection:[HFA] a. formal assessment instruments (e.g., standardized measures of outcomes); b. structured staff assessments; c. careful administrative record reviews; d. narrative data from interviews. Assessment instruments recommended:[HFA] ☒ CAP - Child Abuse Potential Inventory ☐ HOME - Caldwell HOME Observation Measurement Scale (of the NCAST) ☒ PSI - Parenting Stress Index ☒ AAPI - Adult Adolescent Parenting Inventory ☐ NCASTII - Nursing Child Assmnt Satellite Training ☒ MSPP - Michigan Screening Profile of Parenting ☒ MSSI - Maternal Social Support Index RATIONALE: Data collection methods and assessment instruments are subject to a wide variety of human error. For this reason, it is best to gather several different types of *qualitative* and *quantitative* data. The strengths of one type of data are generally the weaknesses of the other type. By including several different types of data, we gain a more complete picture of the complex factors involved in human behavior. This may help inform us not only what changes occurred or did not occur, but also why.	TRA will assist each site in selecting appropriate measurement instruments once staff have decided on the outcomes they expect, based upon the project activities they plan to conduct. TRA expects that the larger sites planning a variety of intervention services will need to develop a more complex Evaluation Pan and utilize a larger variety of assessment tools than will smaller sites who are just beginning to develop family support services. In planning this part of their evaluation strategy, sites may wish to refer also to the *Outline of Potential Program Activities and Assessment Tools* that was included in the Evaluation Orientation Packet for the August 26th training in Helena. TRA will develop any data collection or assessment forms needed by project sites if a suitable tool does not already exist. TRA plans to examine both family outcomes and community outcomes as part of the evaluation process. Community outcomes will likely be examined by means of survey forms that TRA will develop, and through interviews conducted by TRA with staff and community referral sources.	PLANNING DECISIONS: • Are there any *family* or *program* outcomes you wish to document that you feel are not adequately covered by existing measurement or assessment tools? • What types of *community outcomes* do you think should be documented as part of the program evaluation? Portions of the instruments checked in column 1 are included in the *Family Life Survey*.

HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
4. The evaluation data collection system should be fully integrated into a program's ongoing family information system.[HFA] RATIONALE: The data gathered for program evaluation should also serve some useful function for the program staff, by providing information that will aid in planning appropriate family services. The data collection process should include documentation in sufficient detail to allow supervisors to effectively monitor worker and family progress. Experienced staff have also noted that clear documentation of family functioning and the reasons why certain program decisions were made regarding a family can be invaluable on those occasions when they must testify in a court case.	TRA recommends use of a common *Family Contact Report Form* across project sites for use in documenting all families contacts (whether by phone, home visit, group session, day care or other service). It will be important to document type and intensity of services to families in a consistent manner across all project sites, in order to draw conclusions regarding the effects of different types of services in different settings. Such a form could be developed by TRA and field tested at different urban and rural sites. TRA will be using *Paradox for Windows* database software (version 4.5) for data entry. For each assessment form used by any site, TRA will program a database file that is user friendly and looks as much as possible like the paper hard copy of the data collection or assessment form. TRA is prepared to perform data entry and analysis tasks for all project sites. However, sites who wish to have immediate access to the data will be given the option of entering their own data on site. To do this, the site will need to purchase their own *Paradox for Windows* software program (approximately $150), but TRA will provide computer disks with the programmed data file formats free of charge. Please note that *Paradox for DOS* is a different software program, and it is not likely that data file formats will transfer adequately from the Windows to the DOS version of *Paradox*. All project sites will receive data analysis reports from TRA on a periodic basis, regardless of whether they choose to do their own data input or submit the data to TRA on paper forms.	PLANNING DECISIONS: • Do you wish to enter data into your own database program on site, or do you prefer to have TRA perform this task? If you wish to enter your own data, do you have: • an IBM-compatible computer (not *Apple MacIntosh* or *Tandy*)? • the *Microsoft Windows* operating system (version 3.1 or later)? • at least 4 MB of RAM (internal memory space)? • at least 20 MB of free hard disk space? • a video monitor EGA or higher (not CGA)? • a mouse (not req'd, but strongly recommended)? The *Log of Family Contacts and Services* documents: ■ type of services referred and used by families ■ duration of services » service start date » service end date ■ intensity of services: document » length of time each service was provided for family contacts, services, or liaison activities on behalf of families; transportation and other support services provided; amount paid by project funds for supplies or support services, etc.). ■ TRA staff will perform data entry in *Paradox* and create appropriate reports for feeding the data back to program sites. ■ Computerized data entry and report forms will be provided to those sites who request it.

HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
5. Recommended frequency of assessments:[HFA] a. initial assessment of family functioning; b. every 3 mos. for 1st year; c. every 6 mos. thereafter until termination. RATIONALE: 5a. It is important to perform an in-depth initial assessment of family functioning in order to establish a *baseline* from which comparisons can be made with post-program changes in the family or family. 5b/c Families experience enormous changes and stresses during the first year of an infant's life. Such ongoing analyses can provide the FSW with objective feedback as a basis for sound decision-making for case planning.	It may not be feasible to gather all types of assessment information at such frequent intervals. However, it is possible to collect different types of data with varying degrees of frequency; i.e., more time-consuming data could be collected every 6 mos. or yearly, while faster case record and self-report assessment data might be gathered more frequently. Such decisions should be made on a case-by-case basis by each project site, in consultation with the Evaluation Contractor.	PLANNING DECISIONS: A decision must be made regarding how frequently it is feasible to gather each type of data. ■ self-report post-tests of the *Family Life Survey, Basic Needs Survey, and Life Experiences Survey* completed at service termination. ■ service plan summary provided in any form ■ family contact logs kept in any format that documents: family member(s) served, date and length of contact, and type of service provided (using service/ activity codes on PSF-08); and amounts paid or value of hard services provided. ■ family progress reports should be completed at least quarterly in any format that documents service plan goals and the standardized goal achievement scores on PSF-10.
6. Post-program interviews or observations should be obtained on at least a sample of program recipients (3-6 mos. following termination of services). Ideally, this would include the following:[HFA] a. interviews in-person or by telephone; and b. participant status tracked through various administrative records, such as: ☐ Child Protective Services records ☐ Medicaid payments ☐ Welfare records ☐ Dept of Labor (income and job status from employment records) RATIONALE: This type of comprehensive follow-up strategy allows program staff to examine whether improvements in the family or family after involvement in the program are maintained or increased over time.	It would be wise to track such information over a long period of time (e.g., 2-5 yrs following program completion) in order to see how the family situation changes as the child reaches school age. HFA has noted that program staff should try to examine *unintended positive* consequences of family intervention services (e.g., increased economic self-sufficiency); as well as *unintended negative* consequences (e.g., fostering dependency on formal social support systems). This type of follow-up information would be gathered by TRA, with minimal coordination assistance from staff at the project sites. *Release of information* forms must be signed by families upon entry into the program in order to allow for this type of follow-up data collection. TRA has developed a sample form for this purpose.	PLANNING DECISIONS: • What *Release of Information* form will staff use to obtain the necessary screening and follow-up information for all referred families? • Who should administer the *Release of Information* form and when? ■ A short written summary should document reasons why any family referred for services chose not to participate in the program, or terminated services unexpectedly. ■ Service providers will send out a client satisfaction survey form to all families who complete the service program.

HFA/HS RECOMMENDATIONS	TRA (EVALUATOR) COMMENTS	YOUR COMMENTS
7. At least one post-program contact with all families who drop out of services. RATIONALE: Hawaii *Healthy Start* staff have discovered that repeated, persistent attempts to contact families who were initially unwilling to participate in the program have frequently paid off. Such families report that they viewed these persistent contacts by the FSW as proof of a genuine concern for them, and this eventually made them comfortable enough to accept services. In any case, it is important that we gather enough information to help us understand why families refuse services or choose to terminate their involvement in services, in order to develop inventive methods of involving hard-to-reach families in the future.	It is also advisable to collect at least minimal demographic and socio-economic data on persons who refuse services so that it is possible to statistically compare families who accept services with those who reject services (i.e., to develop a *profile* of each). In order to assure anonymity and collect candid feedback, post-program contact should be made by the Evaluator or someone other than the EID or FSW.	PLANNING DECISIONS: What strategies have been devised by your area staff for initial contact and continued involvement with hard-to-reach families who are at high risk for abuse and neglect? ■ A short written summary should document reasons why any family referred for services chose not to participate in the program, or terminate services unexpectedly.
8. Evaluations should include a detailed accounting of how programs: a. established their goals; b. selected their staff; c. determined program content and focus. RATIONALE: These elements are part of a *process evaluation*, as opposed to an *outcome evaluation*. The purpose of such documentation is to produce information in sufficient detail that successful programs can be replicated in similar communities. This also allows a more intuitive understanding of the evaluation results, which helps staff make informed decisions regarding whether adjustments should be made in program content or activities.	As part of the Evaluation Report for each site, TRA will write a draft summary of each program's planning procedures and program content. staff at each site will have the opportunity to review this draft summary and make recommended changes and editing comments. For the purpose of preparing this summary, TRA will probably utilize the following: information in the original proposal submitted to the Montana Department of Family Services; interviews with local program staff and community members involved in the planning and program implementation; and progress notes kept by program supervisors.	PLANNING DECISIONS: Are there other information sources that TRA should utilize in conducting the *process evaluation* for your program site? All workers and supervisors should maintain ongoing case review and program review notes documenting program successes, problems encountered, steps taken to overcome barriers to program success, and innovative steps taken to engage hard-to-reach families.

T E C H

B R I E F

Technical Assistance Brief

Common Questions & Answers Regarding Evaluation Procedures

by Mary A. Trankel, Ph.D., *Trankel Research & Analysis*
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Q1: *Why do we have to use the survey forms that family members fill out? I use a lot of diagnostic tools myself to complete a thorough assessment of my families, and I don't feel comfortable asking them to fill out a lot of paperwork.*

The self-report surveys to be completed by family members include: 1) the **Family Life Survey** (purple form); 2) **Basic Needs Survey** (pink form); and 3) **Life Experiences Survey** (green form). Assessments completed by family service workers and mental health professionals are very important but are insufficient, by themselves, to provide a complete picture regarding outcomes of the service delivery system. These are only part of the picture, because families have their own unique perspective regarding their life situation, and only they can tell us their personal viewpoints and attitudes. Including family members as active participants in the evaluation process can be an empowering technique that is very much in keeping with current treatment protocol -- i.e., building upon family strengths by encouraging them to be active participants in developing a plan to achieve self-sufficiency.

It is very difficult and time consuming to establish the reliability and validity of worker rated assessment tools, which is why most professional researchers rely heavily (and sometimes exclusively) on self-report surveys. Every time a tool is used as an outcome measure, its reliability and validity must be re-established -- regardless of how many others have conducted research designed to establish the credibility of the instrument. Many assessment tools in common usage have never been tested for reliability and validity. If this is not done, a researcher cannot make claims based upon program effectiveness measured by those tools. The enclosed Technical Assistance Brief contains definitions of *reliability*, *validity*, and other research terms relevant to program evaluation procedures.

In order to establish reliability and validity of worker generated assessment tools, the following activities would have to be documented: 1) interrater reliability testing until at least a 70% level of accuracy is established among all workers using the tool (as well as self test-retest reliability for each person using the tool); 2) the person who completes the pre-test assessment and works with the family must not be the same person who completes the post-test assessment (to control for the built-in bias of the worker); 3) there must be statistical evidence of validity (i.e., it must be demonstrated that the instrument is an accurate measure of the concept it is used to measure); and 4) there must be statistical evidence that the outcome being measured (e.g., increased personal empowerment) is correlated with the desired outcome (e.g., decreased aggressive behavior).

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It is understandable that family service workers and mental health professionals want to protect the families they are trying to nurture, especially when such families are thought to be in crisis. However, experience across the nation and with families here in Montana has demonstrated that it is primarily family service professionals who resist use of family self-report instruments. Family members themselves are generally willing to fill out such paperwork, especially if the benefits to them and the importance of research for program improvement is explained to them. Consider the following quote from a Partnership Project family support worker with one year of experience in using the three survey forms devised for this coordinated assessment process: *We continue to be amazed at the opportunity these forms provide us for opening dialogue with new families.*

In the case of families who are at imminent risk of losing their children to the Office of Family Services, additional precautions may help assure them that the confidentiality of their survey responses will be maintained. This is why the ***Informed Consent Form*** **(FBS-04)** was developed. For families who appear reluctant or suspicious, it may help to offer them a stamped envelope, pre-addressed for mailing directly to the research consultant.

Q2: *I don't want to risk alienating families by asking them to fill out forms before I have a chance to establish rapport with them.*

Remember that the purpose of a pre-test is to record *baseline data*. The longer you wait before administering a pre-test, the greater is the danger that positive growth may occur that will not be reflected in the post-test because that change took place before you established their baseline score. For this reason, you will need to use your own best judgement to determine how soon you can approach a new family with the request that they fill out the three survey forms. Partnership family workers have consistently noted that positive attitude changes occur within the first month of contact. When they have waited even one month to ask families to fill out those surveys, the family members themselves often recognize that they would have answered some questions differently before they began working with the Partnership Program.

Even if a family is in a state of crisis, it may be appropriate to ask them to complete the *Basic Needs Survey* by the end of the first meeting, since the questions on that form speak directly to the critical needs at the bottom of Maslow's hierarchy. I encourage you to ask families to fill out the longer *Family Life Survey* no later than the second meeting, if at all possible. Since the *Life Experiences Survey* contains the most sensitive questions, it could be held until about the third meeting, after rapport has been established with the family. However, it is likely that the survey process will be least disturbing to clients if they can simply fill out all three forms at the same time. Please do not forget to have them complete the LES, because research has shown that previous history of being physically or sexually abused is a very strong predictor of a variety of human behaviors.

The questions on the *Life Experience Survey* regarding history of physical or sexual abuse during childhood were taken directly from a national survey that was administered to a random sample of over 4,000 people across the United States, and that survey was successfully completed twice. The questions relating to substance abuse are the same standard questions used by physicians to help determine whether their patients should be referred for substance abuse counseling. The purpose of these three instruments is to provide a means of measuring risk factors relevant to a variety of positive treatment outcomes. Current research findings indicate that it may take a much longer period of time to produce positive change in families where the caregiver has a history of substance abuse, or was physically or sexually abused as a child.

Q3: *Why do the survey forms have to be filled out by the families twice – especially the Life Experiences Survey?*

When self-report surveys are administered prior to receiving services (the *pre-test*) and again after receiving services (the *post-test*), this can provide a type of hard statistical data that is very convincing evidence regarding effectiveness of services. The reliability and validity of surveys can be easily tested using statistical formulas run on the computer. Results of such tests can demonstrate that there has been a real change in the respondent that is larger than what we could have expected from chance alone.

Since historical events cannot be changed, it seems unnecessary to ask people twice about whether they were physically or sexually abused while growing up. However, many family workers predicted that adults would be unwilling to reveal such facts until their worker had a chance to establish rapport with them over a long period of time. Yet there is also evidence that people are actually more willing to reveal unpleasant information to a stranger than to someone whom they have grown to like and respect, because they won't want to risk the possibility of rejection by a new friend. Since we don't yet know which of these hypotheses is correct, we must complete enough pre-tests and post-tests with the LES to provide data to help us decide whether it is possible to get reliable data of this type from a pre-test alone.

Q4: *What steps are taken to ensure confidentiality of respondents?*

The ***Informed Consent Form*** **(FBS-04)** was developed specifically to explain to clients the need for this research data and the precautions being taken to protect their confidentiality and anonymity. It also explains to family members that only the outside evaluator will have access to their specific responses unless they personally authorize anyone else to see their survey data. Notice that the *Informed Consent Form* includes a check box for use if the family member wishes to allow their worker or therapist to have access to these survey results for the purpose of creating an appropriate family service plan.

In the case of families who are at imminent risk of losing their children to the Office of Family Services, additional precautions may help assure them that the confidentiality of their survey responses will be maintained. That is why the Department has hired an outside evaluator to conduct the statewide coordinated assessment process – so we can have the data needed for a sound program evaluation, but clients do not have to worry that Department staff will have direct access to their specific survey answers or information about their life history. One approach that has proven particularly successful is to provide the family member with a stamped envelope that is pre-addressed for mailing to the Evaluation Researcher, so they can be confident that no one else will have direct access to this data. Those family members who fill out the survey forms may request and receive a printout of their own survey scores, which will also show the average scores for all persons in their area who have completed the forms. Offering family members this option may increase their comfort with participation in the research process.

It is necessary for the evaluator to have information that allows identification of persons who complete the surveys, because survey scores must be linked to other data that is being collected from different sources (e.g., demographic characteristics, and follow-up data from the Department regarding numbers of previous and subsequent referrals to the Office of Family Services). TRA cannot complete the types of statistical tests that allow us to examine outcome measures in relation to important independent variables without this ability to track individual clients.

Q5: *Why do we have to use your forms? The forms we've been using cover the same topics and we think our forms are better.*

There is a two-part answer to this question. The first is the issue of which forms or scales are "better." If we are conducting a professional evaluation based upon sound research methodology, we must ask

ourselves the following questions about each assessment tool: 1) what is the established *reliability* of the instrument, and how will reliability of the tool be established in our own research process? 2) what is the established *validity* of the instrument, and how will validity of the tool be determined within our own research process? *[NOTE: An additional Technical Assistance Brief explains the terms reliability and validity.]*

The second thing we need to ask ourselves is: Do our assessment tools measure the factors relevant to our program goals? The Department is interested in examining outcomes of programs that are designed to *protect children and adults by building on community and family strengths*. Therefore, we need assessment tools that will measure those *resiliency factors* that the research literature tells us are related to healthy family functioning, as well as tools that measure factors that place a family at risk for negative outcomes such as child abuse and neglect, substance abuse, and involvement with the criminal justice system.

It is also important to remember that the purpose of a coordinated assessment process is to allow data comparisons to be made across several different programs. For certain types of outcome measures (particularly self-report scales and questionnaires), it is not possible to make such comparisons unless the same tool is administered at all sites. This is the primary reason FBS staff are being asked to use the same tool devised for the Partnership Project. Once we have enough data to establish the reliability and validity of those tools we will be able to evaluate them, or drop and replace items or entire subscales with instruments that are more appropriate for all programs participating in the coordinated assessment process.

The primary purpose of this statewide assessment is not to directly compare the effectiveness of specific programs or program providers; rather, the purpose of using standardized procedures and forms across different program types is to help us determine: 1) how clients being served by the various programs are similar or different (by analyzing demographic profiles of each); 2) how the goals and treatment strategies developed for families are similar or different among program types; and 3) how the risk and resiliency factors identified in the literature can be changed or affected by different treatment strategies and varying lengths of time in treatment. We can learn as much from what does not work as we can from what does work, since both types of information are valuable to workers and administrators who truly desire to improve their services to produce better outcomes for families.

Q6: *Why is the Family Life Survey so long? Can't we cut down to 1 or 2 pages?*

Before we can attempt to change a given behavior, we need to have information that allows us to predict when that behavior might occur. All we know for certain is that the higher the risk factors (and the lower the resiliency factors) in a family, the higher is the likelihood that child abuse or neglect will occur. Therefore, it is logical to assume that if a family support program is helpful in reducing risk factors and increasing resiliency factors within families, the end result is likely to be a reduction or prevention of child abuse and neglect. The *Family Life Survey* (FLS) is designed to measure the following resiliency factors and risk factors: 1) abuse potential; 2) unrealistic child development expectations; 3) child risk factors; 4) coping strategies; 5) depression or unhappiness; 6) domestic abuse potential; 7) personal empowerment; 8) family interaction styles; 9) parenting attitudes; 10) self-esteem or ego strength; and 11) family social support systems. Because of the variation in human responses to different questions, it is sound research practice to develop a scale of several items in order to measure any one psychosocial factor. The average number of questions for each scale in this pilot version of the FLS is 14-16 items. These items were derived from existing scales in common usage across the country that have been rigorously tested for reliability and validity.

After enough data has been gathered, TRA will perform statistical tests designed to determine which of these questions or scales could be dropped from the FLS because they do not meet the criteria for reliability

and validity. While some of these scales may not seem to be directly related to the goals of specific home based services in Montana, it is still possible that these risk and resiliency factors will be positively affected by those programs. This first year of data collection will allow us all to analyze the appropriateness of the FLS items for different family support programs funded through DPHHS. It is expected that these forms will undergo several revisions before everyone is satisfied that they serve as appropriate outcome measures for particular programs. The important thing is that we do not make a priori assumptions ahead of time; but rather wait until we have enough data to test our hypotheses about expected outcomes for families receiving different types of support services.

Q7: *Why are so many of the items on the Family Life Survey worded in a negative way? Aren't we supposed to be focusing on family strengths rather than weaknesses?*

Since the items comprising the *Family Life Survey* were borrowed from existing standardized instruments, they must remain in their original form in order for us to rely on the research findings that established their initial reliability and validity. Unfortunately, most of the existing instruments were constructed with items worded in a negative fashion; i.e., a respondent must *disagree* or *strongly disagree* with a statement in order to obtain a positive score such as high self-esteem or ego strength. The one exception to this is the *Montana Empowerment Scale*, which has a majority of questions worded in the positive direction. Attempt was made to disburse positive and negative questions in a random fashion throughout the *Family Life Survey* in order to avoid *response set* (i.e., the tendency for a respondent to begin using the same response category for nearly all questions). Every scale should be designed to contain a combination of items worded in both positive and negative directions for this very reason.

Q8: *A lot of the families we deal with have literacy problems, and they may be unwilling to fill out the forms just because they do not want to appear ignorant.*

If a family worker suspects that there may be a literacy problem, they should plan to read the questionnaire to the respondent(s) and mark down the answers on the survey form themselves. This can be done in the spirit of a *structured interview* conducted for purposes of gaining important research information and helping the worker to create a relevant family service plan. The important thing is to read the questions exactly as they are worded on the research instrument. You may offer a short definition of a word the respondent seems not to understand, but you should not interpret the questions or offer your impression of how you think they would want to respond to any of the questions. In other words, do not fill out the questionnaire for them or put words in their mouth. Do not act uncomfortable if they need to take a little time to think about a question before answering it. Simply wait patiently until they are able to give a reasoned response. Remember also that there is a strong tendency in all of us to try to be *good research subjects*, by cooperating so much that we try to *guess* what the researcher wants us to say. Therefore, try to exhibit very neutral verbal and body language cues. Appropriate verbal comments should be restricted to an occasional, "I see" or "OK." Try not to act surprised about anything the respondent says or does during the course of the structured interview. If they say anything or give responses that you feel would be good openers for a training session, please try to hold those thoughts until after the interview is completed. If you begin a treatment or learning dialogue too soon, you will start to interact in the role of social worker or treatment professional rather than the role of an unbiased researcher recording objective facts and opinions. Such role reversal mid-stream may confuse your subjects and bias their responses.

Q9: *Why can't we just use Yes/No responses? I don't think my families will be able to use the 5-point Likert scale on the Family Life Survey: SA (strongly agree), A (agree), N (neutral), D (disagree), SD (strongly disagree).*

It is arguable whether a Yes/No scale is easier to answer than a 5-point Likert scale, since most of us do not like to be boxed into a True/False scenario. For example, think of trying to answer a lawyer's questions with a simple Yes or No while you are on the witness stand. We like to think the world allows for opinions in shades of grey, rather than strictly black or white. The major problem, however, is that a Yes/No scale will result in scores computed on the basis of answers that are coded 1 and 0 respectively. Therefore, we have a range of scores = 1 and an average score = .5. With only a one-point range of variation overall, a person would have to move from a very low score (NO self-esteem) to a very high score (HIGH self-esteem) before we could demonstrate a statistically significant difference between pre-test scores and post-test scores. Since we are likely to see only incremental changes in risk and resiliency factors among the families we serve, we need a scaling technique that allows us to measure changes *as they begin to occur*. With a 5-point Likert scale we have scores that vary along a range of 5 points, with an average score of 3. We are much more likely to be able to demonstrate a statistically significant difference between pre-test and post-test scores with this wider variation of choices available to the respondent. This is why a 5-point Likert scale is the *minimum* a professional researcher will use, and often questionnaires are formatted with a 7-point or 10-point scale.

Many people constructing surveys try to create a new set of responses for each question asked, on the assumption that answers which are specific to the questions will be easier because they "make more sense." However, researchers have discovered that respondents generally feel more comfortable with the standard scaling procedure used in the *Family Life Survey*. It takes less time to fill out a questionnaire once you become comfortable with a particular method of responding, and most people are able to figure this out quickly. For the occasional respondent who is truly clueless about how to interpret the response categories, you might help them with the first couple of questions by asking them to choose between two sets of either/or scenarios (being careful not to indicate how you think they should respond). For example, the first item of the Family Life Survey reads: *In our family, everyone shares responsibilities*. Ask the person to consider whether it is *more true* that everyone seems to share in the household chores, or is it *more true* that one person tends to do the majority of household chores. Once they have decided that they tend more toward *agreement* than *disagreement* with the statement, walk them through the second level of decision-making: do they *just agree* or do they feel *very strongly in agreement* with the idea that everyone seems to share in the household chores? If a respondent truly cannot make a decision about whether they agree or disagree with a particular statement, they should choose the *neutral* response, which is essentially an average score for that item (a "3"). If a respondent appears to be using the neutral response too often or too quickly as a means of getting the survey over with, their scores cannot be considered reliable or valid, and the instrument should be re-administered at a later date when they are in a more receptive mood. This reinforces the idea that their input on the survey forms is valuable and important.

Q10: *If I leave the forms with the family, they generally lose them or forget to fill them out by the time I go back for the next visit.*

There is a very high likelihood that the survey forms will be lost or not filled out unless you plan ahead of time to allot part of your visit with the family for the purpose of filling out the forms. Perhaps you could conduct a structured or informal activity with the child(ren) while the adult caregiver completes these forms. However, family service workers have actually experienced some success with sending the forms to the family ahead of time, asking them to have the surveys completed before they arrive for the first visit. This type of strategy is optimal, since the forms will be completed at the true baseline point (i.e., before receiving services or personal contact of any kind). It is particularly effective to offer families a small

gratuity such as a $5 gift certificate, disposable diapers, or complimentary personal items if your agency is able to solicit such donations from local businesses. Offering something of this nature lets the family know that we value their time and willingness to participate in the research process. There is no money available in the research budget to provide such incentives for completing research forms, but if necessary TRA would be glad to assist you in finding creative ways to make incentives available to families who complete the *post-test* instruments in a timely fashion.

Q11: *Which family member fills out the FLS, BN, and LES?*

Those adult family members who will be most actively involved in receiving your services should be asked to complete the three survey forms (both at pre-test and post-test). At a minimum, the primary caregiver should be asked to fill out these surveys, but you may also ask any other adult caregiver or teenage family member to fill out the forms if they are willing to do so.

Q12: *What if the husband insists on being present and wants to answer the survey questions at the same time as his wife? I'm afraid I could be instigating an occurrence of family violence if I insist that they complete the surveys separately.*

In the ideal world of research protocol, it is desirable to have everyone complete their survey forms anonymously and separately. However, in the real world of field research, it is sometimes necessary to make reasonable compromises in specific situations where it seems wise to do so. Partnership Project staff have discovered that, where there is a history or suspicion of domestic abuse, both adult caregivers can be offered the opportunity to fill out the survey forms at the same time. Often the staff person will read the questions aloud, marking both the male and female responses on the same form, by using an "X" to mark the man's responses and circling woman's responses. Experience has shown that the caregivers are usually comfortable with this arrangement, and they do not seem to influence each other's responses because they generally do not answer the survey questions the same way. This process can actually serve as a very valuable training tool because family members are prompted to talk openly about things they have never discussed with each other before.

Q13: *What happens to this data after the forms are filled out and sent in to the evaluator? Will we be able to use the results for family assessment and development of the service/treatment plan?*

TRA has purchased a run-time version of *Paradox*, the database program we use for data entry and report generation, as well as a run-time version of *Parastat*, the statistical program that can be run from within Paradox. What this means is that we can produce a stand-alone data entry and analysis program for any research staff who wish to have direct access to their own client data. You will not need to actually purchase the Paradox database or statistical programs yourself in order to use the computerized forms and reports we produce.

TRA will do all data entry and send hard copies of the data entered (including individual survey results for clients who have signed the *Informed Consent Form* and initialed the box at the bottom to indicate permission for their worker to receive these results). For any research site who requests it, we will provide data disks as well as hard copies of data reports. We will also work with you to generate any data reports you feel would be helpful.

Q14: *What if the family member wants to see his/her survey results?*

The family member filling out the survey may request and receive a printout of his/her own survey scores, which will also show the average scores for all persons in their area who have completed those surveys. Offering family members this option may increase their willingness to participate in the research process.

Q15: *We have a limited budget and staff time is scarce. I don't know if we can afford the staff and cost of photocopying these forms to send to TRA.*

We have not asked DPHHS to produce multiple copies of the data forms at this time because they are still in the process of development. Each research site will need to make enough blank copies of the forms for use by their clients. However, you do not need to make additional copies of the completed forms. If it will save you time and money, you can send the original completed forms to TRA. We will make photocopies of the forms for ourselves and return the originals to you.

Q16: *Is the process of evaluation to convince Legislators to continue to finance the program? We want to continue because we believe in what we do. We are able to see families change. Legislators believe in the program because of the groundswell of support, not because they have been dazzled with facts and figures of people's misfortune.*

The process of evaluation is to determine what types of support services produce the best outcomes for families, so that responsible planning decisions can be made regarding what types of support services to provide for what types of families. Unfortunately, Legislators and other funders are no longer satisfied with subjective feelings and vague assurances that we know our programs are *doing good things* for families because *we can see the changes* in those families. In fact, recent articles in professional journals report that using tactics such as taking Legislators along on field trips to show them what services are being provided to families, and offering written testimonials from families regarding what they liked about the services they received, can actually backfire. It seems that in this age of tight budgets and limited financial resources, Legislators and other funders are not willing to fund programs simply because they make people feel good, and because we verbally assure them that our program *does good things* for families. They do, in fact, want hard statistical facts regarding specific outcomes that have been measured through sound research methodology. This was clearly evident during the last Legislative session when I presented a summary of the proposed program evaluation procedures to the subcommittee. Our Legislators want to know that the people in charge of spending the public's money are doing their best to document the effectiveness of those services. They seem particularly interested in statistical facts that can be used to demonstrate a *cost/benefit analysis* of the services being funded. In other words, they want to know whether the money they are investing in prevention services for families today will provide a reduction in future costs to society because those families will not need more expensive treatments at a later point in time.

T E C H
B R I E F

Technical Assistance Brief

Definitions of Research Terms

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BASELINE DATA: Data documenting the status or condition of a group of subjects on a given variable prior to some type of experimental or treatment intervention. A series of measurements of a client's condition prior to treatment that is used as a basis for comparison with the client's condition after treatment is implemented. For example, before a behavioral therapist would begin trying to change a client's aggressive behaviors, a strategy would be devised for documenting the types of undesirable aggressive behaviors and the average frequency of such behaviors currently exhibited by the client, in order to demonstrate that there has been a decrease in such aggressive incidents following the behavioral therapy intervention. In similar fashion, a family support worker might administer a pre-test self-report assessment to parents in order to measure their attitudes toward use of corporal punishment prior to training the family on appropriate alternative methods of child discipline.

COMPARISON GROUP: A group of subjects in a quasi-experimental or field research design who are not exposed to the treatment intervention (the independent variable), but who have been *matched* with subjects in the treatment group so that they resemble that group on all variables that the researcher thinks might have an effect on the dependent variable of interest (e.g., age, sex, race, level of education, etc.). Since subjects are <u>not</u> randomly assigned to the two groups, we can never be certain that subjects in both groups are truly equivalent.

CONTROL GROUP: The group of subjects in a true experimental research design who are not exposed to the experimental stimulus (do not receive the treatment intervention), but who resemble subjects in the experimental (treatment) group in all other respects. [The basis for assuming that both groups of subjects are essentially equal is probability theory, which draws upon assumptions regarding the uniformity of nature, laws of change, equality of opportunity of occurrence of certain events, and complementary errors canceling each other out if sufficient observations occur.] To constitute a true *control group*, subjects must be randomly assigned to the treatment and control conditions.

CORRELATION: The interrelationship of two (or more) quantitative variables, so that an increase in the magnitude of one of the variables is associated with an increase or decrease in the magnitude of the other. When two variables are highly correlated, it is possible to predict (within a certain degree of accuracy) the magnitude of the dependent variable, based upon knowledge of the magnitude of the independent variable. Correlation is established through statistical testing procedures that indicate: 1) *statistical significance* (i.e., the fact that the observed relationship probably did not occur by chance alone); and 2) an indication of the *strength* or magnitude of the observed relationship (the relative predictive power of the independent variable).

CRONBACH'S ALPHA: Cronbach's alpha is a statistic used to indicate the degree of internal consistency of a scale. The alpha statistic (α) indicates the extent to which all items in the scale are measuring the same general characteristic. Cronbach's alpha is a sophisticated variant of the split-half method of reliability testing (i.e., dividing scale items in half and correlating each half of the scale with the other half). The alpha statistic is computed on the basis of all possible split-half combinations of scale items.

DEPENDENT VARIABLE: The passive variable (the one acted upon or affected by) an independent variable). In a cause-effect relationship, the independent variable is the cause, and the dependent variable is the effect. When a correlation exists between two variables, values of the dependent variable occur or change in a regular, determinable pattern that is directly related to changes in the independent variable.

EVALUATION RESEARCH: The use of scientific research methods to plan intervention programs, to monitor the implementation of new programs and the operation of existing programs, and to determine how effectively programs or clinical practices achieve their goals.

EXPERIMENTAL RESEARCH DESIGN: An investigation in which there is controlled manipulation by the investigator of all variables being studied, and precise observation or measurement of the results. The observation or measurement is carried out under conditions in which it is possible to control all relevant intervening factors, while measuring the effects of an experimentally introduced variable. The investigator assures that both groups of subjects are equal, usually through one of two methods: random assignment of each subject to one of the two study groups (experimental group and control group); or matching all subjects as closely as possible and then randomly assigning each pair of subjects to one of the two study groups.

INDEPENDENT VARIABLE: A variable whose occurrence or change results in the occurrence or change in another variable. In a cause-effect relationship, the independent variable is the cause, and the dependent variable is the effect. The experimental or treatment variable administered to subjects in a research study is presumed to be the independent variable. An independent variable must also precede the dependent variable in time. For example, since gender is established at birth, it must be presumed to be a cause rather than an effect; i.e., one's gender can affect one's role behaviors, but the role behaviors one adopts cannot change their gender. [Well, OK, certain medical procedures can change one's gender, even though they don't precede gender in time, but every rule has its exception!]

INTERRATER (INTERCODER) RELIABILITY: Ability of observers to code behaviors consistently into the same categories of the coding scheme (when using a structured coding scheme). Two or more observers code the same behavior and the resulting codes are correlated to determine the degree of agreement between them (e.g., number of ratings upon which the two raters agreed, divided by the total number of items rated). The more ambiguous a coding scheme, the more difficult it is to establish an acceptable level of reliability between coders. Conversely, the better a coding scheme is operationalized (i.e., data definitions are clearly defined in an objective fashion), the easier it is to train coders to use the instrument reliably. Definitions of coding terms should be refined and reliability tests continued until an interrater (intercoder) reliability score of at least 70% is achieved. **It is important to note that each group of individuals who use a coding instrument must establish the level of reliability for themselves.** It is not enough to assume that use of the instrument will be reliable because some other group of persons used it successfully, because perceptions on appropriate coding strategies may differ considerably.

OPERATIONAL DEFINITION: The concrete and specific definition of something in terms of the operations by which observations are to be categorized; i.e., the precise procedures to be followed in measuring a concept.

PRE-TEST: Preliminary administration of a data-gathering technique or a self-report assessment tool to establish the baseline condition of a subject. Scores obtained after the treatment variable has been administered (post-test) can then be subtracted from the results of the pre-test, and the difference is the result produced by the independent variable (i.e., the treatment).

POST-TEST: Administration of a data-gathering technique or a self-report assessment tool following administration of the treatment condition, to establish whether change has occurred in the condition of a subject or group of subjects. Scores on the post-test are subtracted from scores on the pre-test, and the difference is the result produced by the independent variable (i.e., the treatment).

QUALITATIVE DATA: Data that are not in numerical form. Qualitative data are data in the form of descriptive accounts of observations, interviews, or written material. Examination and interpretation of qualitative data is performed for the purpose of discovering underlying meanings and patterns of relationships. It may also be possible to quantify

qualitative data (e.g., by classifying and counting the number of times certain client behaviors are documented in a social worker's case notes).

QUANTITATIVE DATA: Data in numerical form. Quantitative data are obtained through enumeration and measurement. The numerical representations of data are statistically analyzed for the purpose of describing and explaining the phenomena that those observations reflect. Data may be collected directly in quantitative form, or data originally in qualitative form may be quantified (by converting it into numerically coded categories for statistical analysis).

RELIABILITY: The dependability of a measurement instrument, as reflected in the consistency of its scores upon repeated measurements with the same group of people. Reliability may be measured by giving a measurement to the same subjects more than once to see whether the same results are obtained over time; or by using appropriate statistical tests [such as Cronbach's alpha] to compare different sections of a test that are presumed to be measuring the same general characteristic. **It is important to note that reliability of an instrument must be established separately by each group of individuals who use it.** It is not enough to assume that use of the instrument will be reliable because some other group of persons used it successfully, because perceptions on appropriate coding strategies may differ considerably. Appropriate statistical tests or interrater reliability tests must be conducted for this purpose [see also definition of *interrater* reliability]. *Reliability should not be confused with validity.*

RISK VARIABLES: Certain variables (risk factors) have been found to be statistically correlated with the likelihood that parents will abuse or neglect their children. One risk factor may not necessarily put a family at risk; however, the combination of several risk factors can create stresses difficult for families to manage. Risk factors that may lead to a higher probability of abuse include: single and teenage parenthood, parental isolation, poor coping abilities, lack of social skills, drug and alcohol abuse, unemployment, late or no prenatal care, history of psychiatric care or depression, marital or family problems, history of abuse in a parent's childhood, and low income.

STANDARDIZED MEASURE: A testing instrument (measurement device) that has been subjected to thorough empirical tryout and analysis (i.e., based on experience, observation, or scientific experimentation), and which includes instructions for administration, scoring standards, reliability and validity coefficients, and norms. Standardized instruments have undergone development, testing, research, and revision by social scientists.

STATISTICAL SIGNIFICANCE: Indicates that appropriate statistical tests have been performed to discard the assumption that differences observed between groups might have occurred by chance alone. Thus, the probability of chance influence is so small (i.e., < 5% or 10%) that the researcher can assume (with a 95% or 90% level of confidence) that the observed variations were really due to unique characteristics of the study groups or to the treatment intervention. The type of statistical test performed depends upon how the variable was measured; but regardless of the test used, statistical significance is generally indicated by a *p-value less than the selected level of significance* (e.g., $p < .05$). A significance level of 5% is most common, but the less restrictive significance level of 10% is acceptable for examining small groups of subjects (less than 20 persons).

THREATS TO VALIDITY: Factors that can threaten an evaluation research design because they confuse the true influence of the program with the influence that might have been caused by factors external to the treatment intervention. *Internal invalidity* refers to the possibility that conclusions drawn from research findings may not be valid because the observed outcome was not the result of the treatment stimulus, but rather was caused by some unknown contaminating variable. *External invalidity* refers to the questionable validity of generalizing research findings from a sample of persons to the rest of the population in the "real" world -- again because of the possibility of an unknown effect caused by some contaminating variable.

TREATMENT (EXPERIMENTAL) GROUP: The group of subjects who receive the services or treatment intervention, or are exposed to the experimental stimulus (e.g., a new drug).

VALIDITY: Correspondence between what a measurement instrument is supposed to measure and what it really does measure, i.e., whether it accurately reflects the concept it is designed to measure. The validity of a measuring device is usually determined by comparing the results obtained from that device with an independent and accepted measure of the

same characteristic that has already been established as valid. It is important to realize that the ultimate validity of a measure can never be proven. However, we may agree to its relative validity on the basis of *face validity*, *criterion validity*, *content validity*, *construct validity*, *internal validation*, and *external validation*. [see also *cross-validation*] Validity should not be confused with reliability. Research can be conducted to test the following types of validity:

Face Validity: The quality of an indicator that makes it seem a reasonable measure of some variable; i.e., on the face of it, it seems valid as a true measure. An example might be the *frequency of church attendance* as a valid measure of how *religious* a person is; however, the face validity of this as a valid measure may be disputed by someone who defines *religiosity* in different terms (e.g., Rick O'Shay's horseback ride into the wilderness on Sundays to give thanks to the creator). A common practice among researchers is to select an appropriate "panel" of professionals to independently rate the face validity of each item in a newly designed scale in terms of whether they agree or disagree that the items reflect the concept being measured.

Internal Validation: The process whereby the individual items composing a composite measure (an index or scale composed of multiple items) are correlated with the measure itself. A typical first step in examining the validity of a newly developed scale is to statistically examine the extent to which each item in the scale is related to other items in the scale and to the total scale score. If an item contributes nothing to the predictive power of the scale, it should be excluded. The next step is to explore methods of examining the scale's external validity. Internal validity is an issue in research concerning whether the independent variable is the cause that actually produces the effect it appears to have on the dependent variable.

External Validation: The process of testing the validity of a measurement tool by examining its relationship to other presumed indicators of the same variable. For a person who scores high on a scale designed to measure conservatism, we should be able to accurately predict that they will answer certain political or ethical questions in a conservative manner. External validity refers to the extent to which causal inferences can be made so that findings from a given study can be generalized to other times, settings, or people.

Criterion Validity: The degree to which a measure relates to some external criterion. For example, the validity of the *Scholastic Achievement Test* (SAT) is demonstrated by its ability to predict *success in college*.

Content Validity: The degree to which a measure covers the range of meanings included within the concept. For example, *intelligence tests* are designed to cover a range of abilities related to intelligence, such as *math aptitude*, *writing ability*, and *language skills*. We might argue that the content of such tests is not complete because they do not include a method for measuring such important constructs as *creativity* and *ingenuity*.

Construct Validity: The degree to which a measure relates to other variables, as would be expected within a system of theoretical relationships. For example, Burt has hypothesized that *acceptance of rape myths* should be correlated with such constructs as *acceptance of interpersonal violence as a means of problem-solving, sex-role stereotyping, adversarial sexual beliefs, romantic self-image,* and *sexual conservatism*.

VARIABLE: A characteristic common to a number of individuals, objects, groups, events, etc., which has different degrees of magnitude or different categories (called *values*), so that individual cases differ in the extent to which they possess the characteristic (e.g., number of years of education, scores on a scale measure, type of religious affiliation). In essence, a variable is anything that can *vary* from individual to individual. Variables must be clearly operationalized before they can be measured and statistically analyzed. [See also *independent variable*, *dependent variable*, and *operational definition*.]